# The '*Lecturer*' Practitioner:

# Case Studies of Principles, Purpose and Professional Knowledge

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## Abstract

This study explored the lecturing aspects of the role of five lecturer practitioners (LPs) based in the Faculty of Health in one Higher Education Institution.

Within nurse education the role of the lecturer practitioner (LP) has been seen as a model of good practice (DoH 1999). Simplistically it has often been seen as the solution to a misconceived perception of the theory practice gap in nurse education. Most studies of the role of the LP have been undertaken from the perspective of the clinical rather than the lecturing professional knowledge aspect of the role which this study was designed to investigate.

The case study approach to the investigation was selected as a suitable strategy to examine how individuals functioned in their natural setting (Yin 1994). The study was a multi case descriptive study and adopted a cross case approach to analysis. The cases were assimilated by building up layers of information from data collected via semi-structured interviews, non participant observation and documentary sources. The iterative analytical strategy identified two major overarching themes, The Nature of Nursing and Lecturer Practitioner Professional Knowledge; further themes were identified coded and categorised.

The study concluded that within the key theme of LP professional knowledge; role modelling, delivery of teaching, elaboration and guidance, and reflection demonstrated that within the lecturing aspects of their role the LPs were able to exemplify the intimate and symbiotic relationship between the practice and theory of nursing.

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I dedicate this thesis to my family: my husband Robert, my son David and my daughter Naomi. Their confidence in me has been unwavering and I thank them for their love, wisdom, encouragement and support.

# Author's declaration

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original, except where indicated by special reference in the text, and no part of the dissertation has been submitted for any other academic award. Any views expressed in the dissertation are those of the author.

**Signed** AM Smith **Date** 9th May 2006

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# Introduction

## A personal perspective

This study is an examination of the working lives of five Lecturer Practitioners (LPs) who work in a Higher Education Institution (HEI) and in National Health Service (NHS) clinical areas linked with the HEI. Whilst recognising that the two parts of the role of being a lecturer **and** a practitioner cannot and indeed should not be disaggregated, I was interested to look at the contribution the LP made to the education of nurses in the lecturing aspects of their role. This involved exploring how the individuals developed and functioned as lecturers and how they managed the tensions and dilemmas as well as the joys and rewards of the role. My view has always been that the theory and practice of nursing are inextricably intertwined and I cannot think of any nursing intervention that is not based on some knowledge based theoretical principle even though many may have appeared to be based on ritual rather than evidence. I firmly believe that every practitioner and lecturer, not just LPs, should embody the integration of the theory and practice of nursing in each interaction with every patient or client.

I am also convinced that there should be a partnership between everyone involved in the education of nurses to ensure that the integration of theory and practice takes place within that education. This would involve all those concerned: lecturers who were primarily based in the university setting as well as clinicians who supported students in their clinical learning and LPs who were based in both arenas.

Nursing is essentially a practical profession and it requires clinicians who practice their professional craft in a skilled and expert way. Nevertheless nursing also requires a deep knowledge and understanding of many different aspects of theoretical knowledge in order to provide appropriate care for people. Higgs et al (2001) thought that the two concepts were indeed interdependent and they cogently stated:

> 'The divide often made between theory and practice needs to be removed to understand better the nature of practice and knowledge. Practice and knowledge in the professional context are deeply embedded in each other and operate interdependently'. p4

This was the ideal situation and a far cry from the way in which I was prepared for practice more than thirty years ago. I trained in the days when the comment attributed to 'Anon' cited in Jolly & Brykczynska (1993:1) 'You are not here to think Nurse' was very apposite. I clearly remember early on in my training, questioning a staff nurse about the physiology underpinning the reason why I was asked to take and record the radial pulse rate and

apex beat on a patient who had Congestive Cardiac Failure. I was firmly told 'You don't need to know that, just do it'. Student nurses were an integral part of the nursing workforce and thus provided a substantial amount of the actual hands-on care to patients. Even though some of the theory supporting practice was taught to students, the cultural norms of that time were clear that it was not important. The overriding concern was for the work to be done and to be done efficiently. As I progressed in my career as a nurse and into nurse education the issue of how theory and practice related to each other became an ever greater concern. I was more and more aware of the fact that I was teaching about clinical nursing without actually coming into contact with patients or clients in any meaningful way. I was convinced that my understanding of the reality of practice was likely to become stale if not downright fossilized. At the same time I was convinced that by having a thorough understanding of the issues involved in how student nurses were educated and the best way to enable them to understand the principles of theory behind practice I could still play a significant part in their education. My instinctive feeling had always been that the LP was a key person who was in an ideal position to demonstrate the embodiment of theory and practice within the education of nurses. However I was also aware that the issues were highly complex and that the LP was only one of many people who would contribute to educational programmes. In 1999 the Government review of nurse education (Department of Health [DoH] 1999) identified the role of the LP as a model of good practice and the role of the LP came to the fore. The time was right, therefore, for this study to take place, which aimed to examine the lecturing aspect of the role of the lecturer practitioner.

## Focus and aims of the thesis

Within the context of the relationship between the theory and practice of nursing the study clearly set out to explore the lecturing aspect of the LP role and to look at the distinctive ways in which the LPs taught students in the classroom situation. Alternative ways of carrying out this could have been undertaken, for example a comparative study could have been mounted considering the differences between aspects of the lecturing practice of LPs and other lecturers in the faculty. However I wished to undertake a detailed examination of the working lives of a sample of the LPs in post in the faculty at the time of the study. This would require a detailed exploration of each individual LP in an attempt to understand them as people and 'what made them tick' as well as exploring their

professional practice within the HEI and their contribution to the education of nurses. With this in mind the following aims of the study were identified.

To:

- document the forms of knowledge and skill that lecturer practitioners bring to the education of nurses.
- understand the perceptions and experiences that lecturer practitioners have in their role in the education of nurses.
- elucidate the distinctiveness that lecturer practitioners have in the education of nurses.

A case study approach to the research was identified as a suitable methodology as the study aimed to explore how individuals functioned in their real world (Yin 1994). The cases would be built up from different data sources; interview, observation and documents in order to present as full a picture of each individual LP as possible.

## Structure of the thesis

The thesis is structured in four parts with sub-sections in each part. **Part One** details the Introduction and Context to the thesis presenting an historical and professional perspective on the development of nurse education from Florence Nightingale to the present time. The idea of a Lecturer Practitioner is then examined in detail with reference to the literature. The initiation and development of the role is explored in some depth and specific research studies are examined. An exploration of the literature revealed that most studies had looked at the role of the LP from perspective of how they worked with students in practice. There was very little literature, only one study, which explored the role of the LP in relation to its impact on student learning in the classroom setting. This deficit in the literature provided the opportunity for this study to be undertaken with its focus clearly on investigating the lecturing aspect of the LP role.

**Part Two** of the study outlined the methodology of the study in order to meet the aims of the research and detailed the rationale for the methods and strategy selected to undertake the investigation. The research questions were outlined and a rationale was provided for the case study approach to the study. Issues such as; sampling and selection of the participants, data collection methods, analytical strategy, and ethical considerations were described and discussed at some length. As the analytical strategy is detailed the

emerging themes of the investigation become evident.

The whole of **Part Three** is the presentation of the five case studies. In congruence with the analytical strategy (Miles & Huberman 1994) the presentation of the cases required an integration of the three main sources of data and in the first and second stages of the analysis a compression of the large amount of information collected in each case. From the large amount of data each case is written as a narrative, describing each participant and highlighting key aspects of their biography and life as a LP.

**Part Four** the final part is concerned with the discussion and inferences gained from the study. The discussion is based on insights derived from the rich data acquired from the study of the lives of the five LPs. It is focused on an exploration of the key themes of; the Nature of Nursing and Lecturer Practitioner practice. Firstly there is an analysis of the concepts the LPs identified as being key components within the nature of nursing. Secondly there is a detailed examination of the practice of the LPs in the lecturing aspects of their role.

The conclusions and the implications of the findings of the study are presented with a brief discussion of possibilities for further research. An exploration of the shortcomings of the approach to the research and the design of the study are also presented in this final part.

The study ends with postscript outlining the current position of the LP participants within the institution.

## Context and Background

### A historical perspective on the development of nurse education

Until the middle of the nineteenth century the preparation of nurses for practice was almost non-existent. Nursing the sick was thought to be common sense and women's work (Baly 1994). Florence Nightingale who, as Baly declared, became 'a legend in her own day' (Baly 1994:111), was the person who changed the face of both nursing and the preparation for the practice of nursing. In the autumn of 1854 she was asked by Sydney Herbert, who was a close friend as well as the Minister at War, to take a group of nurses to the Crimea to assist in the care of sick and wounded soldiers. She was under no apprehensions as the difficulties she faced in the task she had been given and she insisted that all the nurses in her party were subject to the strictest discipline and answerable to her at all times. She was very aware of the expedition to the Crimea being a test of her and her nurses; however she was also aware that it could be ' an experiment that could prove the value of good nursing to the world' (Baly 1994 :115).

In the Crimea she set about organizing the nursing care of the soldiers in a systematic way. She highlighted the fact that lack of sanitation and hygiene and other basic facilities were the major killers of the soldiers. Baly (1994 p117) stated that:

> 'Of the 98,000 British soldiers who took to the field 22,000 had died and of these *17,000 had died from disease'.*

The Crimean war had been a military disaster; the organization of the British army was shown to be sadly deficient and such nursing as had been available before Florence Nightingale was 'at its worst poor and unsupervised and at its best devoted and unscientific' (Baly 1994 :117).

At the end of the Crimean War a Fund was set up by Sidney Herbert to collect money from the people of the United Kingdom for a suitable worthy cause which would be a lasting and fitting public acknowledgement of Florence Nightingale's contribution to the war. The nation was enormously grateful to her for what was seen as her almost saintly efforts in the care of wounded and dying soldiers. The money raised was used to set up the first training school for nurses at St Thomas' Hospital. The probationers, as they were called, received some theoretical instruction from doctors but their main role was as part of the nursing workforce providing actual care to patients on the wards. Miss Nightingale saw the moral nature of the preparation of nurses as the most significant aspect of their training. This was illustrated in the preamble of the application form for the duties of a

probationer for St Thomas' Hospital 1861-1871:

> 'You are required to be sober, honest, trustful, trustworthy, punctual, quiet and orderly, clean and neat.' cited in Dingwall et al (1988 :54).

However, this preoccupation with a high standard of morality should be seen not only in the context of Victorian middle class morality but in contrast to what had been the norm of the ignorant care of the sick provided by gin-soaked women such the fictitious Sarah Gamp (Dickens 1843) whose character was based on many real life examples.

Some of the nurses produced by the Nightingale system of training became nursing leaders and their ideas were taken up across the country. For example Rebecca Strong, who trained at The Nightingale School at St Thomas' Hospital and who later became the matron of the Glasgow Royal Infirmary, was an advocate of university education for nurses. She promoted the idea of the training of nurses being as important as the their providing actual care to patients. She was convinced of the necessity for nurses to have sufficient theoretical preparation for the role. Margaret Huxley, who trained as a nurse at St Bartholomew's hospital, was highly influential in Ireland; she espoused the need for a scientific education for nurses and in 1894 she set up a training school for nurses which was linked to all the hospitals in Dublin (McGann 1992).

In spite of the success of the Nightingale system of training, Baly (1994) claimed that many of the exponents did not have her creative imagination or charisma and they concentrated too much on discipline and obedience with an authoritarian approach which had its own disadvantages for the profession. She observed:

> 'Obedience breeds conformity, and an unquestioning profession was bred that was resistant to change'
>
> Baly (1994:122)

Nevertheless, following Nightingale's influence nurse training was certainly more organized and hospitals became much more civilized places both for the patients and staff. However nurse education continued to be predominantly hospital ward based with probationers first and foremost being required to provide care with haphazard, often inadequate, theoretical input. There was no national standard of training and the only evidence nurses were able to provide to potential employers about their competence to practice was their hospital certificate.

At the end of the nineteenth century a movement led by Mrs. Ethel Bedford Fenwick emerged with the aspiration to ensure a uniform training for all nurses in the country. She

was convinced that a sound education was the portal to professional recognition and that this would attract intelligent women into nursing:

> 'The era of the "ministering angel" and the silly sentimentality inseparable from that aspect of the work, and which did so much harm, has, we hope, as completely passed as the days and degradation for ever associated with Sairey Gamp. The era of the trained nurse as a woman desirous to do the best possible professional work in her power has dawned.'
>
> Bedford Fenwick (1901) cited in McGann (1992:55)

The battle for registration was waged for over thirty years before The Nurses Registration Act of 1919 was passed by Parliament. Much of the resistance came from doctors and administrators but much more crucially Florence Nightingale was opposed to a national register of nurses. She was of the opinion that a national system would undermine standards, that it would compromise the personal supervision of probationers and the moral content of the training. It was really only following her death in 1910 that the way became clear for registration to proceed, but the First World War delayed the legislation until 1919.

Numerous reports and reforms which led to slow and very gradual changes characterized nurse education over the next fifty years (Baly1994). However, nurse education was still based in hospitals and student nurses were a substantial part of the work force providing care to patients. There was little concern about theoretical concepts being applied to practice, as there was so little formal knowledge within nursing. The whole emphasis of preparation for practice was on doing the job and learning as an apprentice by doing it. It was unusual for nurse lecturers to be graduates of any academic discipline and often they were expected to teach any subject on the curriculum to any group of students. Champion (1992) was of the opinion that this approach to the education of nurses produced "a static view of knowledge" (Champion 1992:30). She argued that it inhibited integration of academic knowledge with practice and led to a negative view of how research and the generation of knowledge could relate to the reality of nursing practice.

**Recent developments in nurse education**

Nurse education at the beginning of the twenty first century was situated in a highly dynamic public policy environment. Successive Governments had made enormous legislative changes to health care provision and delivery with an acceleration from the early 1990s when the internal market in health care was initiated. The changing focus from secondary care to primary care and, through health promotion to enable people to lead healthier lives, led to profound changes in the way in which nurses functioned (DoH

2002a, 2002b). In terms of preparing nurses for practice it was clear, therefore, that there was a continuing and constant requirement for a dynamic and pro-active approach to the education of nurses.

The key moment which precipitated change to the way in which nurses were trained occurred when Briggs (1972) reported on the future of nurse education; he proposed radical changes to the way in which nurses were prepared for practice. Changes to the regulation of the profession were also suggested at this time and as a result the regulatory body the United Kingdom Central Council for Nursing Midwifery and Health Visiting was set up in 1979 with four National Boards in each country of the United Kingdom. The new professional body debated Briggs' ideas and ultimately a new programme of preparation was developed which incorporated many of his proposals. The new programme, which had its first student intake in 1989, was known as Project 2000. It was educationally led and on successful completion students were eligible for the award of Diploma of Higher Education in Nursing as well as being deemed competent to practice as a nurse. It was designed to meet the demands for a more highly educated work force and it aimed to prepare the nurse to be a 'knowledgeable doer' (United Kingdom Central Council [UKCC]1985). In addition, following the successful completion of the Diploma of Higher Education, students could continue their studies part-time to degree level. Programmes were devised in collaboration with higher education institutions, some of them in the original departments of nursing, others in polytechnics or colleges of higher education. As the programmes were educationally led for the first two and a half years of the course students were supernumerary in practice environments; however they became part of the ward team for the last six months of the programme.

These changes to nurse education coincided with the enormous expansion in higher education at the end of the twentieth century with several waves of new provision being established (Halsey 1995). Following the Robbins report (1963), several new universities were founded, including the Open University, and the polytechnic sector, with an emphasis on vocational education, was established. In 1992 the binary line in higher education differentiating between universities and polytechnics was dissolved and all former polytechnic institutions as well as some other higher education establishments were granted full university title with the autonomy to award their own degrees. During the last two decades of the twentieth century nurse education and the education for most other health care professional groups moved from small monotechnic institutions or NHS hospitals to affiliations and ultimately mergers with higher education institutions. In line

with the earlier concept of training nurses the aim of programmes had been to prepare students for a license to practice awarded by a national professional body and was not linked with a specific academic level. Under the new system within Higher Education, which was concerned with educating students for a profession, they were eligible for the award of a Diploma of Higher Education or in some cases a Degree as well as a license to practice as a Nurse Midwife or Health Visitor. The organization and delivery of nurse education within higher education was directed and controlled by nurses themselves as opposed to being heavily medically dominated as had been the case in the previous system.

Reviews of the new programmes published in 1999 (UKCC Peach report and DoH) commented that even though they had developed the intellectual skills in students, concern had been expressed by employers that the programmes had not enabled students to develop the skills necessary for competent practice. There was a feeling that the impetus to strengthen the academic content of the programmes had caused the pendulum to swing too far away from enabling students to develop practical skills. Following the reviews, a new programme of preparation was introduced designed to redress the balance. It still aimed to provide an intellectually rigorous programme based in higher education but with a closer collaborative partnership with the National Health Service so that students' practical skills could be developed more effectively. Students were exposed to practice at an early stage and were often attached to a specific ward or health care area for the first part of their course. They were therefore able to contribute as part of the health care team and to see how nursing care was delivered to patients over a period of time. The role of the LP in facilitating students to develop clinical skills and practice knowledge was emphasized by both reports. One of the recommendations stated:

> 'It is important that, as with medical education, nurses are taught by those with practical and recent experience of nursing... There are many good models of lecturer-practitioners... that both benefit students and give experienced staff the value of working in a learning organisation... We intend to create more opportunities for experienced staff to combine teaching and patient care so that students can acquire better practical skills. We are also determined to enhance the status of those who provide practice-based teaching.'
>
> Department of Health (1999:27)

At this time also a review of the nurse education staff in the University College (Allan 1998) indicated that there was an urgent need to attract younger staff into the Faculty who could demonstrate clinical competence in specific areas of nursing or midwifery practice.

The LPs in the study were employed as a response to these reviews and it was in this context that they came into post.

**The professionalisation of nursing**

As a result of substantial educational, social and organizational reforms, nursing at the beginning of the twenty-first century had developed many of the characteristics required to be able to be regarded as a profession. However, following recent reports and enquiries into the conduct and actions of certain individuals and professional groups (Kennedy 2001, Smith 2004 and Laming 2003), now, more than ever before, the concept of being a professional is being hotly debated. Hoyle & John (1995) asserted, "Profession is an essentially contested concept" (1995:1), they held that knowledge and responsibility were essential components of being regarded as part of a profession. Freidson (2001) echoed the importance of knowledge and responsibility being key criteria of a profession. He asserted that for an individual having a moral responsibility within work was a major characteristic in differentiating an occupation from a profession. He stated:

> 'The ideal-typical position of professionalism is founded on the official belief that knowledge and skill of a particular specialization requires a foundation in abstract concepts and formal learning and necessitates the exercise of discretion.'
>
> Freidson (2001:34-35)

Within this definition of a profession nursing has begun to develop a body of knowledge upon which practice is based, with some of the theory being founded on supporting disciplines in the life and social sciences (Champion 1992). Thus the knowledge requirements identified above have been met. The concept of nursing having an element of discretion or responsibility in it was an idea that has been held closely by nurses since Nightingale's time. Entry to registration for the profession to this day requires the director of the programme to make a declaration as to the candidate's personal and professional suitability to become a registered practitioner. A key element of a profession is the ability to regulate itself and to ensure that new entrants from their initial preparation for practice met the standards required for practice. The educational programmes in higher education developed, taught and managed by nurses themselves and the regulation of nurses by their own professional body ensured that nursing could clearly be seen to regulate itself, with nurses themselves as the gatekeepers to the profession.

Davies (1995) maintained that there was a gendered approach to professionalism where so-called masculine ideals of objectivity, competitiveness and predictability were

considered to be key criteria of the concept. She asserted that a new understanding of the nature of professionalism was required where the so-called feminine attributes of care, nurture and personal interaction were accorded as high a status and value as the masculine ideals. Beach (2002) was concerned that nurses through their adoption of professional status with its esoteric body of knowledge put a barrier between themselves and the people they cared for. She thought that an essential element in nursing practice was health promotion, which aimed to share information with patients in order to empower them to make informed choices about issues such as lifestyle or medical care and treatment. She made the case for the practice of nursing to have equal parity of status with academic knowledge and crucially for nurses not to lose the caring element of the role. This opinion was endorsed by Gallagher (2005), who reasoned that nurses were in danger of losing their core values, the caring element of the role, in their desire to be seen as professional practitioners. Beach (2002) concluded her argument by affirming that nurses should resist conforming to the concept of a professional ideal and that they should find ways to gather knowledge and skills together in a way which would reflect the specific and special nature of nursing practice.

Beach (2002) did not mention LPs specifically; however, she was concerned about the nature of the practice of nursing and how this would be taught to future generations of nurses. These concerns, combined with the relationship between knowledge required for practice and knowledge of theory, were the very issues that the LP role was set up to address.

## The specific context of the study

The study was undertaken in the Faculty of Nursing Midwifery and Social Work in a Higher Education Institution in the South of England. There were five faculties in the HEI; Education, Nursing, Midwifery and Social Work, Health Sciences, Arts and Humanities, and Management and Business Studies. Most of the activity within the HEI was in the realm of the education of professionals in the public sector.

The Faculty of Nursing Midwifery and Social Work had five departments and the LP subjects in the study were drawn from the four nursing departments. Two subjects were in the Acute Nursing department, one was in the Continuing Care Nursing department, one was in the Midwifery Child and Community Nursing department and one was in the Mental Health and Learning Disability department. The Faculty had approximately ninety

academic staff of which seven were Lecturer Practitioners. The role of the LP in the faculty was a relatively new one and there had been some attempt to secure funding from local NHS organizations to continue the posts in order to continue to further develop the partnership between the HEI and the NHS. At the time of undertaking the study the position was unclear as to how the role of LP would be supported or developed in the future. However, there was some commitment from both the academic institution and NHS and Social Care providers to continuing to develop the partnership by supporting a small number of LP posts.

## The Idea of a Lecturer Practitioner

The LP is now a well-accepted role in nurse education; however, many commentators have agreed that it has proved to be an elusive concept to define adequately (Wright 2001, Landers 2000, Fairbrother & Ford 1998). Newman et al (2001) asserted that it was seen as the vehicle to improve clinical effectiveness by addressing what was seen as the perceived gap between 'academic' and 'practical' nursing. The role of the LP was endorsed by the Government publication Making a Difference (DoH 1999) which explored ways of strengthening the nursing, midwifery and health visiting contribution to health care. Further, the contribution of LPs to the practice and education of nurses was affirmed by the professional body (UKCC, Peach1999).

Elcock (1998) stated that she could find no definition of the term LP in any nursing dictionary; however she was of the opinion that the most commonly cited definitions were those provided by Vaughan (1990) and Fitzgerald (1989) both of whom were involved with the implementation of the role in Oxford in the nineteen eighties.

The role was developed as a result of a unique collaboration between the Health Authority and the Higher Education Institution (Lathlean & Vaughan 1994, Elcock 1998). A new undergraduate programme of preparation for all nurses provided the catalyst for a partnership which resulted in a radically different approach to supporting student nurses in the integration of the theoretical and practical aspects of their programme. A feature of this approach to the curriculum was a commitment to supporting students in practice; this initiative provided the impetus for developing the LP role (Champion 1992, Burns & Bulman 2001). It was clear that there was always an element of flexibility in the way in which individual LPs interpreted the focus of the role. Vaughan (1990) took the view that the LP role had two distinct areas of responsibility embedded within it:

> 'to identify and maintain the standards of practice and policies within a defined clinical area; to prepare and contribute to the educational programme of students in relation to the theory and practice of nursing in that unit'
>
> Vaughan (1990:109)

Vaughan (1990) understood the role to require having expert power as an experienced nurse to lead and influence the standards of practice in a specific clinical area, in contrast to the hierarchical authority of a manager. However, Lathlean (1995) in her longitudinal ethnographic study of LPs identified that having authority as a manager for clinical practice was an important element of the role.

Fitzgerald who was one of the first LPs defined the role as:

> 'a senior nurse who has mastery of practice, education, management and research through demonstrating these collective skills s/he is able to lead a team of nurses delivering a professional service to patients, at the same time developing personal skills and knowledge in him/herself and the nurses working alongside.'
>
> Fitzgerald (1989:13)

Fitzgerald clearly understood the role to be rooted in practice as it was developed through leading and working with a team of nurses. She included education in the definition but it would appear that it had less emphasis than the clinical aspects of the role. She also emphasized the professional and personal growth of the LP and the team as the role evolved.

Champion (1994) identified four models of LP distinguished by different roles and responsibilities for clinical and educational practice:

> 'LP as Senior Sister and Ward Manager
> LP in a collegiate role
> LP as Senior Sister and Advisor
> LP as Ward Manager'
>
> Champion (1994: 9-10)

She thought that each of these models had its own particular focus and strength, with three of them having a clear responsibility for the day-to-day running and management of a ward or unit. The remaining model, the collegiate model, which Champion asserted had the weakest structure, could nevertheless be seen as being the most flexible. The LP was identified as being a senior member of the ward or unit team but s/he had no day to day responsibility for the management or organisation of the clinical environment. Champion (1994) was clear that in all models of working the LP role was soundly conceived, and she was of the opinion that it had had a positive impact on the clinical learning environment of students. She believed that the role enabled students to learn, through practice, to become reflective, analytical professionals able to question their own practice and that of colleagues in order to provide the best care for patients.

Another definition of the role was offered by Day et al (1998) in a research study commissioned by the English National Board for Nursing Midwifery and Health Visiting (ENB) on the Role of the Teacher/Lecturer in Practice. They noted that a LP was an experienced practitioner who had a role in the education of nurses as it was carried out in Higher Education as well as in the clinical practice environment. They defined the LP as a

person who:

> 'holds an academic appointment but spends a proportion of contracted time in the practice setting'
>
> Day et al (1998:4)

This was a broad, open ended definition which focused on where the LP worked; for example either in academia or in a practice setting. No specific mention was made of what activities the LP was involved in with respect to each aspect of the role and of what responsibilities they had in each area of their professional practice or even if it was necessary for them to have specific clinical responsibilities in the role.

In a report prepared for the Chief Nursing Officer on 'LP Roles in England' Hollingworth also used a broad definition and defined a LP as:

> 'as an individual who is accountable to a trust for service provision and to a university for education provision'.
>
> Hollingworth (1997:1)

The survey found that the concept of a LP was appropriate, and that the incumbents were likely to be well qualified clinicians at the peak of their careers and as such were a significant resource within the profession. Notwithstanding this, it was further found that there was a lack of recognition of the value of the LP, funding to support future development was problematic and that the benefits of the LP role had not been clearly demonstrated. A specific recommendation was that:

> 'Research is required to establish the clinical and educational cost effectiveness of the lecturer practitioner role.'
>
> Hollingworth (1997:4)

Elcock (1998) in her analysis of the concept of the LP was of the opinion that the literature was almost unanimous in its agreement that LPs were introduced to be a human bridge in what was seen as the theory/practice gap. Indeed it had been argued that because LPs worked both in academic (theory based) and clinical (practice based) settings they were in an ideal position to bridge the gap between the two areas. However Newman et al (2001) contended that this was a simplistic stance and that it misjudged the complexity of both the theory and practice of nursing and of nurse education. Lathlean (1995) commented that traditionally nurse education had seen theory as being synonymous with 'theoretical instruction' Lathlean (1995:5), which took place in classrooms in a school of nursing. She also identified that practice referred to the experience that students had when on clinical

placement in a ward or a community health setting. Sadly, often the two were taught and experienced in isolation from each other and theory was seen to be irrelevant to what students experienced in the reality of the practice of nursing.

Garbett (1995) looked in detail at the theory/practice gap and he argued that in nursing there was still a notion that theory and practice were separate entities. He stated that nurses often appeared to accept that theory and practice were concepts diametrically opposite to each other even though many of them did not have a coherent idea of the composition and intricacy of each concept. He opined that when theory and practice were examined a complexity of meaning became apparent; he further commented that it may even be desirable not to reconcile them and to live with the apparent paradox. These ideas were also echoed by Meleis (1991). The idea of the dynamic tension between the two concepts was also endorsed by Rafferty et al (1996). They argued that in the professional practice of nursing the relationship between theory and practice should be reciprocal and that theory should support practice in the same way that practice informed theory. They asserted that student nurses should be exposed to the debates surrounding the origins of nursing knowledge in order to enable them to deal with the equivocal and unpredictable nature, the 'swampy lowland' Schon (1987:3) of professional practice.

Elcock (1998) also identified that successful implementation of LP posts required that they be supernumerary, and that each practitioner needed to be able to define their own way of working based on their individual skills and attributes to meet the needs of the local situation. These ideas were most akin to the collegiate model identified by Champion (1994). Elcock (1998) argued that, crucially, managers in both service and education must be committed to supporting the role in order for it to succeed. This was supported by Lathlean (1995), Fairbrother & Ford (1998) and in a study exploring the lecturer/practitioner role from a phenomenological perspective undertaken by Nelson and McSherry (2002). Williamson et al (2004), who undertook an action research study of LPs, also agreed with these findings. Further, Elcock (1998) thought that almost as important was the need for practice to be valued by nurse educationalists. Ideas which had been previously proposed by Champion (1992) and Stitt (1995). Additionally, she affirmed that for the role to succeed LPs must have excellent interpersonal, organisational and time management skills. Finally, she identified that LPs should have an academic qualification at least at first degree level and a recognized teaching qualification or be willing to undertake such a qualification.

Fairbrother & Ford (1998) commented that in order for the role to be developed to its full potential the lower status of practice in relation to theory in nurse education should be confronted. They suggested that this could be done by valuing the complexity of clinical practice and the academic demands of practice learning and teaching. Sternberg & Caruso (1985) discussed the status of practical knowledge in relation to other forms of knowledge. They commented:

> 'Despite its signal importance in our everyday lives, perhaps no form of knowledge has been less highly regarded, and more noticeably disregarded, than practical knowledge.'
>
> Sternberg & Caruso (1985:155)

and they urged that the academic community should more carefully consider practical knowledge than heretofore.

Glen & Clark (1999), in response to what they identified as the complex demands on nurse educators, proposed a new approach. They held that a number of roles should emerge on a continuum between theory, with nurse educators based in a HEI, and practice with the experienced clinical nurse, who would teach students as and when appropriate in the clinical setting. This would mean an evolving and dynamic approach to the education of nurses and, as they stated, this 'offers possibilities allowing nurses to slip and slide between educational and practice arenas' Glen & Clark (1999:18)

In response to criticism from NHS employers concerning the fitness to practice of newly qualified nurses, two comprehensive reviews of pre-registration nursing programmes were undertaken. They culminated in reports from the Department of Health (1999) and the UKCC (UKCC, Peach report 1999). Both recommended that students should be exposed to practice at a much earlier stage in the programme and that a much more comprehensive and extensive support system for practice should be set up. A number of different and innovative ways were identified to support students in their clinical learning situations. In many areas some of the ideas proposed by Glen & Clark (1999) were put in place, with some experienced clinical practitioners having a more explicit responsibility for student support and some lecturers having a more focused role in the link activity between the higher education institution and clinical practice. The role of the LP in support of student learning was seen to be even more crucial than before in the change of focus in the new programmes of preparation (Redwood 2001, Aston et al 2000, Leigh et al 2002, Williamson 2004 and Williamson et al 2004). A continuum of support between the academic and clinical aspects of the programme was developed, with a range of practitioners making a contribution and with LPs playing a central role in this. In an

extensive search of the literature it appeared that most of the studies explored the role of the LP from the perspective of how they worked with students in practice, and significantly, how they related theory and practice. Driver & Campbell (2000) was the only study found which aimed to evaluate the role of the LP on student learning in the university setting. They undertook a small study in one institution with pre-registration nursing students. They found that LPs were pragmatic in their teaching of current nursing practice, using up-to-date knowledge derived from research upon which to base the content of their sessions. Further, they identified that the students found this approach academically invigorating and helpful in supporting their clinical learning. Moreover, these findings were less evident when they analysed student learning with other lecturers. Therefore, Driver & Campbell (2000) suggested that the impact of LPs on student learning should be investigated further. As has been stated the literature found only one study, the one mentioned above, which considered the impact of LPs in the academic setting on student learning and no studies were found which aimed specifically to examine the professional knowledge underpinning LP practice. It was apparent that there was a deficit in the literature and it was appropriate therefore that this study aimed to explore this knowledge gap further.

**The Specific requirements for Lecturer Practitioners in this study**

For the purposes of this study Lecturer Practitioners were defined as:

- being a registered nurse
- having a minimum of three years of practice experience within which they had developed a clearly identifiable clinical specialist role
- being graduates of a relevant discipline
- having either completed an appropriate Masters degree or were undertaking one
- having either completed or were undertaking an appropriate teaching qualification, usually a Post Graduate Certificate of Education (PGCE).
- spending the equivalent of at least two days a week in clinical practice

Additionally, they all had excellent interpersonal skills, which were vital in order to individually negotiate their role in both practice and educational settings. Broadly, they operated in what could be described as the collegial model identified by Champion (1994) who stated that in this model of working:

'The Lecturer Practitioner:

- works alongside a senior sister or ward sister and is a senior member of the ward or sub unit team
- is not responsible for either sub unit nursing resource management or day-to-day ward organisation.'

Champion (1994:9)

Four of the LPs were employed by the HEI and were attached to a specific area or areas of practice working alongside a ward manager as a senior member of the ward team. However they did not have responsibility for the day-to-day management or organization of the ward or unit. One of the LPs remained in the employment of an NHS Trust and he made individual arrangements to continue to work for two days a week with the ward team he had been involved with before moving into his present post. Champion (1994) held that the collegiate model did not enable the post holder to exert considerable influence on ward policy but it did permit the incumbent to be fully available to support students and to work with staff in practice. This model therefore was seen to be very successful in influencing practice on the ward or unit. Some of the success of the role may be attributed to the enthusiasm and excellent interpersonal skills of the LPs concerned.

Before taking up the post all the LPs had been in practice for a minimum of three years and most had been in practice for considerably longer. All were identified as having developed as an expert in practice (Benner 1984) and had either worked as a ward manager or had been responsible for an area of practice. They were all identified as having excellent interpersonal relationships as people who were also committed to the practice of nursing or midwifery as enthusiastic clinicians.

All the LPs were graduates; two had completed a Masters degree and the other three had embarked on one. In order to meet the requirements of the Professional Body for teachers of nurses they had also each completed a PGCE. They had responsibilities in the educational institution as well as in clinical practice areas.

Each LP managed their own way of working on the ward area or unit but, broadly speaking, as well as having clinical responsibility for a number of patients or clients, practice responsibilities involved: advice to colleagues about professional educational development, supervision of students on pre- and post-registration programmes, practice development initiatives and involvement in policy making.

Similarly the educational responsibilities varied with each individual; classroom based teaching with the concomitant lesson preparation and marking was a major component of

their work. However, they were also concerned with curriculum development initiatives, student tutorials and leadership of and contribution to the delivery of specific modules on pre- and/or post-registration programmes.

## Summary

All the subjects were able, articulate, registered professional practitioners with a clearly defined area of clinical expertise, which, through their current practice, they continued to develop. They were academically well qualified and had undertaken a teaching qualification. They all made a significant contribution to the development and delivery of the curriculum on various programmes in the University College. Additionally, in the practice setting, they were a valuable resource for colleagues, students, managers and policy makers.

# Part Two

# Methodology

## Research aims

The study aimed to:

- document the forms of knowledge and skill that lecturer practitioners bring to the education of nurses.
- understand the perceptions and experiences that lecturer practitioners have in their role in the education of nurses.
- elucidate the distinctiveness that lecturer practitioners have in the education of nurses.

## Research questions

In order to develop the research aims three broad research questions and further sub-questions were formulated.

1. What principles and beliefs underpin the practice of lecturer practitioners?

    In what ways have personal biographies and experiences shaped the knowledge and practice of the lecturer practitioners?

    How are lecturer practitioner values about professional development expressed?

2. How do lecturer practitioners relate their understanding of what it means to be a professional nurse/midwife to their practice?

    In what ways do lecturer practitioners use their clinical knowledge and expertise in their practice?

    In what ways do lecturer practitioners articulate their distinctive role in the education of nurses?

3. What form of professional knowledge and practice do lecturer practitioners bring to the education of nurses?

    What types of knowledge and skill underpin the practice of lecturer practitioners?

    What processes and trends can be discerned in the evolution of the lecturer practitioners' professional knowledge?

    What learning and teaching strategies do LPs employ to engage students in the

professional learning process?

**Rationale for the use of qualitative research methods**

Given that the purpose of this study was concerned to document the forms of knowledge and skill that lecturer practitioners bring to the education of nurses, to understand the perceptions and experiences that lecturer practitioners have in their role, and to elucidate the distinctiveness that they have within the education of nurses, a qualitative methodology was adopted. Qualitative research methods provide the opportunity to explore the real world and lived experience of individuals (Robson 2002). Miles & Huberman (1994) asserted that qualitative approaches to data collection are very appropriate for eliciting the meanings individuals put on the mundane as well as the significant events in their lives. They also contended that these meanings were connected to and influenced by the context within which people lived i.e. their social world. Holloway & Wheeler discussed ideas from Weber who emphasized the interpretivist view of the nature of knowledge and the importance of understanding which they reasoned was 'inherently different from explanation in the natural sciences' Holloway & Wheeler (2002:7). They argued that it involved a 'reflective reconstruction and interpretation of the action of others' p7. These ideas were endorsed by Hammersley (2002) who, when discussing the ethnographic approach to research stated that:

> 'people *construct* the social world, both through their interpretations of it and through the actions based on those interpretations'
>
> Hammersley (2002:67)

Holloway & Wheeler (2002) explored the characteristics and aims of qualitative research and they opined that there were common features within the qualitative approaches. They acknowledged that: firstly, in qualitative research the data were of primary importance; secondly, new theoretical ideas were generated from the data themselves; and thirdly, often the research design was modified and adapted as the research progressed with the focus constantly being based on the data. They affirmed that:

> 'Qualitative research is not static but developmental and dynamic in character; the focus is on *process* as well as outcomes.'
>
> Holloway & Wheeler (2002:11)

They argued that in order to understand the context of the lives of the respondents researchers must immerse themselves in the setting in which the study took place. This

would also enable them to focus on the process of the research. In order to do this researchers would have to constantly challenge her/his assumptions about the world of the respondents. Holloway & Wheeler stated that they should 'act like strangers in the setting' (Holloway & Wheeler 2002:12). Further, they claimed that by being immersed in the research setting researchers would not just be concerned with superficial description, but would move towards 'their interpretations, uncovering feelings and the meanings of their actions' (Holloway & Wheeler 2002:13).

**Case Study**

A case study approach was deemed to be the most appropriate strategy given the research questions. Yin (1994) and Denscombe (1998) were of the opinion that case study was a suitable tactic to employ for a study which was designed to investigate how individuals functioned in their real world. Additionally, Yin (1994) commented that case study aimed to investigate the subjects in their natural setting when there was no control by a researcher over the context in which they worked, and this was the situation in the current study.

Yin (1994) stated that case study research:

> 'is an empirical enquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident'
>
> Yin (1994:13)

Cohen et al (2000) noted that case study often pursued the interpretive paradigm of research, which was concerned to understand situations from the participants' perceptions. This was in contrast to the positivist approach, often thought of as the traditional approach to research, which was based on science and objectivity and where the research was concerned with generalisability and causal explanations. Cohen et al (2000) observed that interpretivist approaches to research, including case study, have been criticized for being soft forms of enquiry which were not legitimate forms of research. However, they commented that this criticism was based on prejudice rather than on a systematic critique of the totality of the methodological field of research. In the past the lack of rigour of some qualitative studies, particularly those using case study, brought the approach into disrepute (Atkinson & Delamot 1985). Yin (1994) strongly contended that case study was remarkably hard to undertake; further he held that "paradoxically the 'softer' a research strategy, the harder it is to do" (Yin 1994:16). Cohen et al (2000) concurred with this and were of the opinion that case study data should be collected

methodically and rigorously.

Yin (1994) stated that there were single case studies and multiple case studies and that although case study has been aligned with the interpretive tradition of research, quantitative as well as qualitative sources of evidence could be used. He identified that there were three types, exploratory, descriptive and explanatory, which were categorized according to the outcomes of the case study. He claimed that case study was a particularly appropriate strategy when the research was involved with 'how' and 'why' questions of current concern. Cohen et al (2000) reasoned that the holistic nature of case study research meant that the whole case could be seen to be made up of more than the sum of its parts.

Stenhouse (1975) identified four types of case study: ethnographic single in-depth study, action research, evaluative and educational. In contrast Stake (1995) distinguished three types of study: intrinsic, instrumental and collective. Collective case studies were designed to elicit a fuller picture of a particular phenomenon. Cohen et al (2000) were of the opinion that case studies provided depth and fine grain detail of phenomena or situations which could be used to augment larger scale studies, which would inevitably have a more superficial approach.

Adelman et al (1980) identified several advantages and Nisbet & Watt (1984) outlined strengths and weaknesses of case study. They agreed that case study demonstrated a reality that other research approaches lacked. However, Adelman et al (1980) thought that the data were difficult to organize, in contrast to other approaches which may be low in reality but more easily organized. They commented that case study had a down-to-earth approach which often accorded with the readers' experiences and they opined that case study had a particular capacity to demonstrate nuances and the intricacy of the issues under consideration. They reasoned that the richness of the data collected provided the opportunity for reinterpretation of the information by other researchers.

However, Nisbet & Watt (1984) maintained that the weaknesses of case study were concerned with issues of generalisability of the findings and the subjectivity of the researcher. It could be argued, nevertheless, that these criticisms could be made of many qualitative research approaches. Indeed, one of the major differences between the qualitative and quantitative research paradigms was the place of the person undertaking the research within the study and of the fact that the purpose of qualitative enquiry was to explore and illuminate an area of interest rather than to prove or disprove an hypothesis.

Issues of rigour and method were significant in case study and qualitative research as in the positivist tradition (Holliday 2002). Terms such as 'reliability' and 'validity' which were appropriate in quantitative research paradigms were more sympathetically expressed in terms such as 'trustworthiness', 'dependability', 'credibility', 'transferability' and 'confirmability' in qualitative research (Holloway & Wheeler 2002). In addition an audit trail of the process and the way in which the research was conducted was crucial to ensure transparency of method.

Cohen et al (2000) argued that case study was concerned with significant issues and with quality of information as opposed to quantity:

> 'Case studies in not having to seek frequencies of occurrences, can replace quantity with quality and intensity, separating the *significant few* from the *insignificant many* instances of behaviour. Significance rather than frequency is a hallmark of case studies, offering the researcher an insight into the real dynamics of situations and people.'
>
> Cohen et al (2000:185)

They argued that even though it may be appropriate to note typical events and occurrences in case study research it may be equally significant to record critical incidents which provide crucial insights into the subject being scrutinized.

The present study could be seen to be a multi-case descriptive case study which adopted a cross case approach to analysis utilizing elements from grounded theory as well as concepts from Yin (1994). Each case was assimilated by building up layers of information, providing a fine grain picture of each of the subjects being studied. This was done by conducting two semi-structured interviews with the subjects followed by non-participant observations of at least two teaching sessions and scrutiny of relevant documentary sources.

**Selection of participants**

At the time of the study there were seven LPs in post in the institution who met the criteria for inclusion as they had been in post for two years and had developed an understanding of the norms and expectations of them in the role.

**Figure 1**

**Table showing selection of LP participants for this study**

| Name | Age | Gender | Specialism | Clinical level | Academic Qualifications | Selection for this study |
|---|---|---|---|---|---|---|
| Amy | 40s | F | Midwifery | Junior Sister | BSc Midwifery | Yes |
| Ben | 30s | M | Mental Health | Junior Charge Nurse | BSc Biology | Yes |
| Jane | 30s | F | Adult Nursing | Senior Staff Nurse | BSc Biology | Yes |
| Liz | 40s | F | Community | Senior Practitioner | BSc Social Science | No |
| Mary | 30s | F | Adult Nursing | Senior Sister | BSc Nursing MSc Nursing | Yes |
| Peter | 40s | M | Adult Nursing | Senior Charge Nurse | BA Social Science MA Health Studies | Yes |
| Roz | 40s | F | Community | Senior Sister | BSc Nursing | No |

The two LPs who were excluded from the study were female and in their 40s, and they had a similar professional background. They were senior practitioners and had been so for some time; they both had a first degree and were working towards a master's degree. However the main criterion for their exclusion from the study was that they were *my* close colleagues. Their principal role in the University College was to contribute to the programme she led and it was felt therefore that it was not appropriate for them to be included in the study as there was some risk of a conflict of interest between their work and the research.

The participants who were selected could therefore be seen as a convenience and purposive sample of the LPs in post in the University College at the time the study was undertaken. In terms of age, gender, experience, clinical background and academic qualifications they were representative of the LPs in post in the Faculty.

Each of the five participants was approached individually and asked if they would be

willing to participate in the study. The purpose of the project was outlined to them and they were told that the research was concerned with undertaking 'a study of the lecturing aspect of the working lives of lecturer practitioners'. There was some discussion about the fact that the lecturing and practice elements of the role were intertwined but, nevertheless, that the focus of this research was to understand more about the lecturing aspects of their role. They were assured that the information obtained for the study would be treated with the greatest respect and that every effort would be made to ensure the confidentiality of the information obtained. The way in which the research would be undertaken was outlined to them and they were told that they would be provided with a draft of their individual case and they would be asked to comment on its accuracy. Further, it was emphasized that they were at liberty to request that information was removed or modified if they were not entirely happy about the way in which their case was presented.

**Data collection methods**

Cohen et al (2000) outlined the need to distinguish between the emic and etic analysis of research data. In the emic approach the researcher attempted to document the insider's understanding of phenomena. They might then be able to offer some explanation as to why people acted in particular ways. Holloway & Wheeler (2002) argued that this perspective was essential in order not to impose an outsider's perspective on the events being scrutinized. They commented that in order to do this effectively, listening to people about their experiences was the essential approach to understanding their views. In this study an emic approach to the collection and analysis of the data was what I aspired to achieve in order to develop an understanding of what the subjects understood to be important and significant for them. I was myself part of the same academic community as the LPs so I had a deep and detailed understanding of the way in which the organization worked and influenced its staff. However, I was very aware that I was a lecturer, not a LP; and that my experience of working in the organization was unique to me and I attempted to avoid allowing my ideas and experiences to have an influence on the data. I reflected on ways in which I could bracket my own ideas and feelings in order to enable the 'voice' of the subjects to be clearly heard in the analysis.

**Semi-structured interviews**

In the initial planning, in order to address the aims of the study, different approaches to

the way in which the data were collected were considered. In order to explore the real world and working lives of the LPs it was thought that the data should be collected and information gathered in a way which allowed the subjects to provide their own perspectives on the issues. The adaptable approach of the semi-structured interview was identified as a suitable method of collecting one aspect of the data. It allowed some control and focus to the study to be maintained during the interviews, and therefore, while at the same time it enabled the participants to express their own views about the way in which they had developed their career and currently undertook their role. It also permitted the interview to be conducted in an informal way in a conversational manner, even though a set of prompt questions were used to guide the interaction (Holloway & Wheeler 2002). Robson stated that "interview is a kind of conversation; a conversation with a purpose" (Robson 1993:228). However, he emphasized that as interviews for research have a specific purpose, they required a rather different emphasis in the interaction between the interviewer and the interviewee than that which takes place in ordinary conversation. He opined that the researcher aimed to enable those being interviewed to talk openly about the subject of the interview. He identified four things which would enable this to happen: interviewers should listen more than they speak, they should pose questions in an open clear way, they should not provide cues for the interviewee which could bias the responses, and they should endeavour to enjoy, or at least to appear to enjoy and be interested in, the process of conducting the interview. Interviews might also allow discussion to take place around the issues which had been identified both by the interviewer and the interviewee. Yin (1994) made the point that respondents may for these purposes be called informants; they would have an active role in the research and may be able to suggest other sources of evidence to corroborate the evidence that they themselves provided. The interviewer should be aware that he/she might have an effect on the interview (Cohen et al 2002). For example the age, sex, ethnic origin, and occupational status of the interviewer may not be things that can be altered but they might have an effect on the way in which the interviewee reacted and responded in the interview. I was aware that as a colleague of the subjects and a more experienced lecturer. It could be construed therefore that there was an unequal relationship between the subjects and me and that this might have inhibited them from expressing their real feelings and ideas in response to the research questions. I tried to promote an equal relationship between the respondents and myself but I had to consider the possibility that I would influence the findings. Denscombe (1998) suggested that passivity and neutrality

should be the hallmarks of the good interviewer, with the researcher's 'self' and own views on the issues being kept in check. Conversely, Oakley (1981) argued that the researcher might have an objective to empower the subjects of the study and therefore they should enter into discussion with the subjects in order to achieve these aims. In this study, and particularly as discussed above, equality of relationship between the subjects and myself was what I endeavoured to achieve and therefore Oakley's notions about interviewing were highly germane. Cohen et al (2000) also emphasized the need to plan and prepare for the interview. This required careful planning in relation to preparing the venue, checking the equipment as well as preparing for the interview. Nevertheless it should be remembered that in whatever way the interview was recorded, as Powney & Watts (1987) maintained, that interview was:

> 'a means of collecting talk, then it is perhaps important to remember that talk is dynamic - a quality it loses as soon as it is collected in any way'
>
> Powney & Watts (1987:16)

They suggested that some means of collecting data were better at capturing the dynamic nature of the interview than others. They commented that interviews were most commonly recorded by using video or audio tapes or by taking field notes of the interview, but they stated that any method of recording would only capture a very small amount of the data that the whole interview produced. The non-verbal communication may be missed in audio taping, and any means of collecting data may intrude on the interview and will possibly produce different data than if the recording device was not present. The impact of the technology or written means of recording the interview must be taken account of even though it would be very difficult, if not impossible, to measure its impact on the interaction. In this study field notes were kept from which checking and augmenting of information from the interviews was undertaken. The field notes and the transcriptions were sorted, coded and amalgamated in order to provide as accurate and rich account of the interview as possible.

The first interview covered various issues in relation to the individual LP's personal and professional background up to the point where they became a LP. Firstly the biography of each participant was explored, and information was elicited about his or her childhood and formative years. The purpose of the interview was to enable the participants to articulate some of the specific influences which had determined their beliefs and value systems in relation to their practice as nurses and ultimately as nurse educators. They were able to explore and articulate the scientific knowledge upon which their practice was

based. The final part of the first interview explored issues about the participant's professional career and development. It aimed to examine how the participant saw themselves as nurses and it allowed them to discuss their feelings about nursing and what issues were important to them as practitioners.

The second interview was concerned with the participant's practice as a LP. Issues were discussed, such as how they had developed in the role, how they perceived their role and purpose, and what distinctiveness they saw it having in the education of nurses. The interview also explored with the individual LPs the tensions and rewards of the role.

**Non participant observations**

As one of the aims of the research was to examine how the LPs contributed to the education of nurses it was entirely logical that teaching sessions should be observed to see how they actually taught students. At least two teaching sessions were observed and tape recorded. As a non-participant observer I aimed to be as discreet as possible in the class room setting rather like a 'fly on the wall'. However I was aware that there would inevitably be some effect on the setting of my being present and I aimed to keep this effect to minimum by being as unobtrusive as I could.

Cohen et al (2000) commented that the researcher should keep as full notes as possible of the observation as it is being undertaken. Drawing on the work of several authors they suggested that data should be collected on phenomena such as the context of the setting, the characteristics of the participants, the resources used in the activity being observed as well as the behaviour of the participants in the group to each other and to the leader/lecturer in this instance. Spradley (1980) suggested that researchers should note the physical setting, events, activities and actions, timing and goals of the activity, what people are feeling and how they expressed these feelings. It was also suggested that the researcher should develop a reflective perspective on the research. This would involve reflection on the description and analysis of the data, the methods used to collect the data, ethical tensions or dilemmas, the researcher's own reactions to what had been observed as well as a perspective on the need to clarify points or issues from the observation and in what ways the inquiry could be taken further. Spradley (1980) also asserted that normally observations involved three sequential steps, moving from description to a more focused perspective and finally to observation of selective phenomena.

LeCompte et al (1997) suggested that there were specific issues that should be noted in observations. They involved questions that the researcher should ask of her/himself, specifically issues concerning who is being observed, what is happening in the observation, where does the interaction take place, when does the observation occur and why do people act or interact in the way in which they do.

The observed teaching sessions took place in various classrooms in the University College. I positioned myself and the tape recorder as unobtrusively as possible in a corner of the classroom; I made extensive field notes of the observation, taking particular note of the issues identified by Spradley (1980).

**Documentation**

Four of the five subjects provided written material in the form of handouts and supplementary information given to students. In relation to documentary evidence Yin stated that 'the most important use of documents is to corroborate and augment evidence from other sources' Yin 1994:81). In this study documents provided useful information to support the pedagogical strategies that the subject used. For example the incomplete handout of the very detailed anatomy of the male and female reproductive systems illustrated what that LP required of the students and gave an indication of how she was able to support them when she provided the completed diagram on an overhead transparency.

Robson (2002) commented that documents could be used as an unobtrusive data source as they were not affected by their use in a research investigation. In this study the documents that were available were those given to the students, and in some cases the LP's lesson plans were also provided. Robson (2002) also opined that the content and context of the documents could illuminate their purpose in the institutional, social and cultural domains. They were therefore potentially useful supplementary sources of information within an investigation. Documents could reveal and illuminate the goals the lecturer was aiming for in the session, the teaching methods, any strategies used to evaluate the session as well as the values of the lecturer, shown in the way in which the written material was prepared for use. For example, were the documents prepared meticulously, with attention to detail and direction to other sound written sources, or were they hastily prepared with little apparent thought behind their presentation? In addition, supporting documentation in the form of a report for the University College on the LP role and a job description for the LP role were also made available.

## Triangulation

The concept of triangulation was originally concerned with physical measurement, for example in navigation, where several markers were used to allow a particular location to be homed in on and identified. It has been used by researchers to develop as full a picture of an issue as possible. Cohen et al (2000) stated:

> 'triangular techniques in the social sciences attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint'.
>
> Cohen et al (2000:112)

Bowling (1997) opined that triangulated research approaches are those where three or more methods are utilised in order to investigate a specific issue. Yin (1994) asserted that 'a major strength of case study data collection is the opportunity to use many different sources of evidence' (Yin 1994:91). Further, four types of triangulation were identified by Yin: 'data sources, investigator triangulation, theory triangulation and methodological triangulation' (Yin 1994:92). Denscombe (1998) held that the use of multiple sources demonstrated validation of the data. Additionally Yin (1994) affirmed that:

> 'the most important advantage presented by using multiple sources of evidence is the development of *converging lines of inquiry*... any findings or conclusions in a case study is likely to be much more convincing and accurate if it is based on several different sources of information'
>
> Yin (1994:92)

Data triangulation in the form of interviews, observation and documentary sources were employed in the study and were used to develop the fine grain picture of each LP. The different methods enabled a comprehensive rounded case study to be built up of each of the subjects. Denscombe (1998) argued that the different forms of evidence acquired by triangulation enabled the researcher to '*see the thing from different perspectives* and to understand the topic in a more rounded and complete fashion' (Denscombe 1998:84).

## Pilot study

The study demanded different approaches to the collection of the data from the respondents. It was felt therefore that it would be helpful to undertake a pilot study to ascertain whether the methods proposed to build up each case would prove to be an effective way of collecting relevant data and information. A lecturer colleague kindly agreed to an audio taped interview and to having one teaching session observed and tape

recorded. Two semi-structured interviews were undertaken and field notes were made of the teaching session. Ethical issues in relation to the way in which the pilot study was conducted were discussed with the colleague and ethical principles were adhered to in the same way as in the main study.

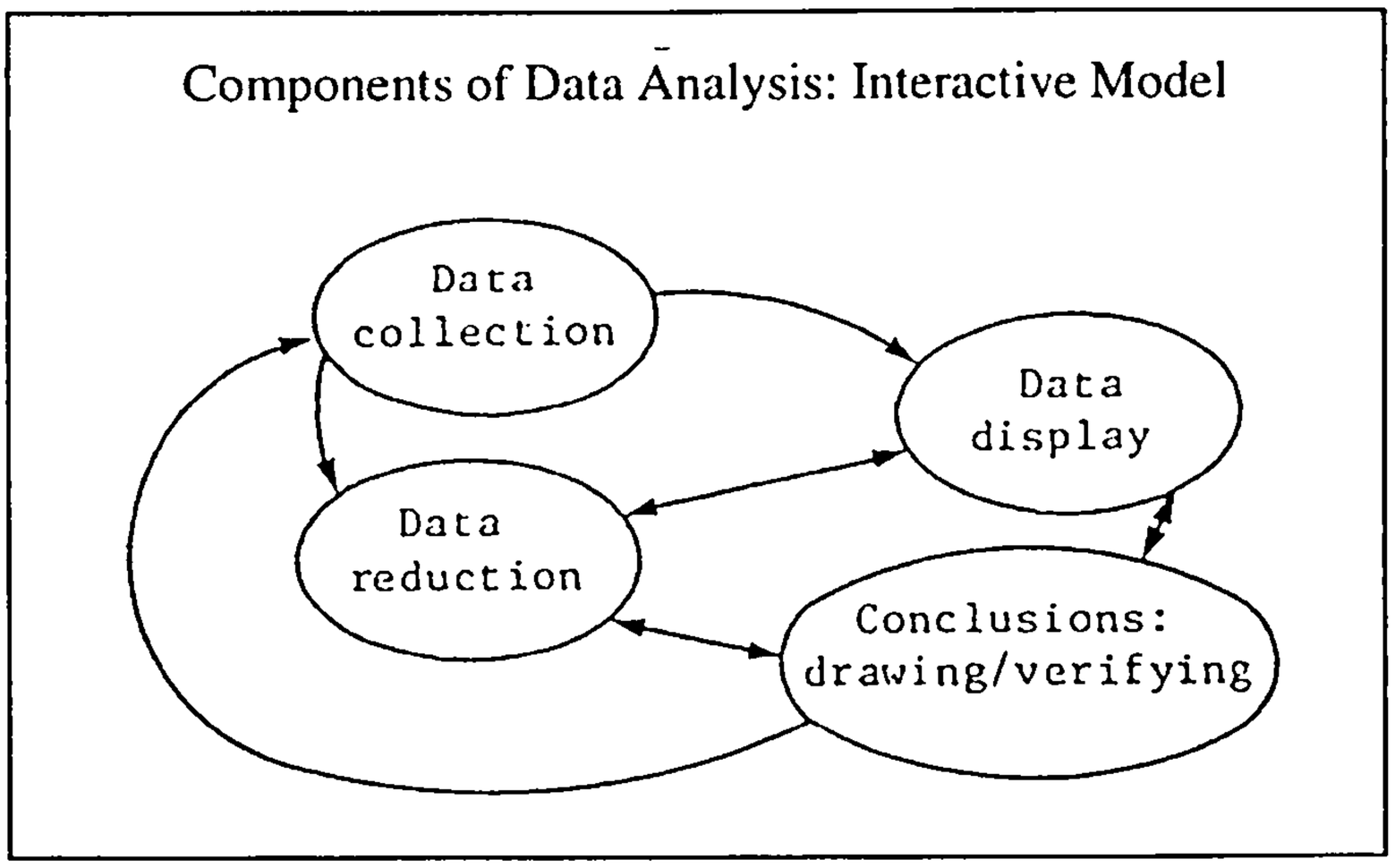
Following the pilot study the interview schedule was slightly amended before the main study proceeded with the five participants.

## Analytical strategy

Miles and Huberman argued that 'qualitative data analysis is a continuous, iterative enterprise' (Miles & Huberman 1994:12). An analytical strategy was developed which drew upon the work of Yin (1994), Miles & Huberman (1994) and Eisenhardt (2002) as well as utilizing some concepts from grounded theory (Strauss & Corbin 1990 and Burnard 1991). Following the data collection three stages of analysis were evident: data reduction, data display and conclusions.

**Figure 2**

**Stages in the analysis**




Miles & Huberman (1994:12)

### Stage one: data reduction

In qualitative research the process of analysis starts with the collection of the data (Cohen et al 2002, Holloway & Wheeler 2002). Therefore the data were reflected on as they were

being collected and notes were made of any occurrences or issues that were felt to be significant. Following the interviews each tape was transcribed verbatim and the transcripts and audio recordings were checked, amended and augmented as necessary from the field notes. The recordings and field notes of the observed teaching sessions were written up in detail to provide as full an account of each session as possible.

Miles & Huberman stated that the process of data reduction involved 'selecting, focusing, simplifying, abstracting and transforming the data' (Miles & Huberman 1994:10). Further, they held the view that data reduction was a constantly occurring process in all qualitative research studies. A continuous iterative strategy was adopted bearing in mind concepts from Cohen et al (2000), which emphasized the need to focus on significant occurrences rather than merely frequency of events or activities. These ideas were endorsed by Holloway & Wheeler (2002) who affirmed that it was crucial at this stage in the analysis to manage and organize the large amount of data that would have been generated.

A strategy was developed to guide and manage the building up of each case. A selection of the most significant information was made and some other material was discarded. For example it was clear that some aspects of the participants' backgrounds, although intrinsically interesting, were not relevant for this study and in order to retain the focus would need to be sifted out and excluded from each case. From the initial interviews there was a large amount of material relating to the participant's childhood, background and what had influenced them to take up nursing as a career. For instance in Jane's case her comments about her grandfather's last illness, which had occurred when she was a student, had clearly had a profound effect on her and she felt that it had influenced her to consider nursing as a career. It was clear also that Mary and Amy may have unconsciously both been influenced to take up a career in nursing by the fact that their mother and sister were nurses.

Similarly, the second interview with each participant provided a great deal of information about the lecturing aspect of his or her role as a LP and it was necessary to focus on significant issues or occurrences. This could be seen in how Peter's case was built up from the vast amount of data. Key elements from his second interview were sifted and distilled. This was done by noting and underlining specific issues and significant occurrences in the text of the transcripts and reflecting on the field notes (Cohen et al 2000). It was clear that when he discussed his daily work as a LP a recurring theme was his desire to influence students' approach to patients. It was clear that he thought that his

role was to challenge assumptions and attitudes and that he aspired, through teaching physiology, exploring ethical aspects of care and presenting his own values and understanding of nursing, to enable students to reflect on how they themselves delivered care to their patients.

As the analysis progressed the data from the observations were compressed. However, the focus was maintained and the seminal aspects of each session were selected for inclusion in the final case. For instance, the reaction of the students to particular issues as they were being discussed, or any particular way in which the lecturer and the students interacted during the session, were noted. An example of this was seen in the session Mary took on the management of pain; the interaction between her and the student for whom the theory underpinning practice suddenly made sense was the focus of a memo (Holloway & Wheeler 2002).

The student animatedly said:

> 'I mean that would make such sense, I didn't actually realize all that before I can't understand why we don't do more like massage'

Mary nodded encouragingly and said 'uh huh'. The student continued:

> 'I always knew that there was scope for alternatives but I just think now why, why are we not doing more, why are we not touching our patients more? It's just - what are we doing? What are we not doing? What have we been doing?'

Mary agreed and said:

> 'It's amazing isn't it, you know it's just straight forward clinical things like touching your patient. It doesn't have to be where the pain is necessarily, just the fact that you are touching them will send, will stimulate those fibres, will probably increase the secretion of serotonin and therefore will make them feel better anyway, even if it does not relieve the pain entirely. So that's the basis of why people feel better when they are stroked or massaged.'

Similarly in a session when Ben discussed the reality of caring for patients with dementia significant note was made that the students were totally absorbed in what he was talking about and 'hung on' to his every word (Cohen et al 2000 and Holloway & Wheeler 2002).

Ben said:

> 'For a patient with dementia they will forget who they are, who their loved ones are, communication will be disrupted, there may be the risk of injury, there will be a loss of independence, a loss of dignity, a loss of autonomy and a loss of insight and awareness.'

In order to illustrate this further he discussed the idea of a return to childhood that many people said happened in people who had dementia. He stated:

> 'People don't return to childhood, but where that phrase comes from is that there are skills that are learned from childhood, you are not born with the ability to do certain things, you are not born with the ability to feed yourself or to tie your shoelaces, it is a skill that is leaned. In dementia it is often said that skills for life are 'unlearned' people lose the ability to do certain things. I detest the phrase personally because people have not returned to childhood they have just lost the ability to do certain things and inside there is still the mature person who has had a full life with all that that means.'

Within this initial aspect of analysis simplifying and transforming the data further required identifying key elements within it in order to present a coherent display of the data (Miles & Huberman 1994).

**Stage two: data display**

Miles & Huberman (1994) compared data display to other forms of display seen in everyday life, and they concluded that displays enabled an understanding of what was happening to occur, and to take relevant action and/or draw appropriate conclusions as a result of that understanding. They reaffirmed that the display of data was an integral part of the whole analytical strategy of the research as an aspect of the iterative nature of the analysis of qualitative studies. Miles & Huberman (1994) indicated that in qualitative studies data displays were often presented in the form of illustrations, charts or matrices. However in this study the data were displayed in the form of five case studies of each LP; these are presented in Part 3 of the study. The cases were a composite of the compressed material from the interviews and observations and were essentially a descriptive account of each individual. As outlined above, significant occurrences and issues were concentrated upon when building the final case. A format for presentation was arrived at and this provided a fairly consistent approach to their presentation while still allowing for some individuality in each case.

The final cases were presented in a narrative style using notions and ideas drawn from the work of Connelly & Clandinin (1990), Hatch & Wisniewski (1995) and Winter et al (1999). Initially the narrative style of writing was difficult to execute and many drafts of the cases were written. Eventually, having looked at the work of Bassey (1999), the way in which the 'Dear Emma' letter (Bassey 1999:161) was written was found to be particularly helpful in understanding how information and ideas could be presented in a narrative style. This could be done without falling into the trap identified by Cohen et al (2000) who cautioned case study researchers against anecdotal approaches to reporting studies. Specifically they urged against:

> 'journalistic approaches, selective reporting, banal and tedious illustrations,

pomposity, and blandness.'

Cohen et al (2000:182)

The completed case was then given to each of the participants who were asked whether they felt that it was an accurate interpretation of the data that had been collected. Each participant made comments on the case and amendments were made as necessary. Most of the amendments were in relation to minor points of accuracy of detail of the information. I then had a short discussion with each of the participants to ensure that they were happy with the way in which the case had been presented within the study. Following this conversation amendments were made as necessary and each case was presented in its final format.

**Stage three: conclusion drawing and verifying**

At this stage of the analysis the issue of the meaning that could be discerned from the data was the overriding concern. These ideas had been in the back of my mind from the outset of the study but now they came to the fore and were the focus of this part of the analysis.

Eisenhardt (2002) advocated a within-case analytical strategy to clarify emerging themes within the data. She argued that by having a constantly critical reflective approach to each case study, in comparison with and contrast to the others, a sharper focus of the key issues was allowed to emerge. This was done in the analytical memos which noted ideas and thoughts about the data and posed questions about early emerging themes. She further contended that this tactic allowed the distinctive outline of each case to become evident before any generalization between cases was made. It also had the additional benefit of requiring the researcher to become immersed in the data, which in turn facilitated the process of cross-case analysis.

Similarly Holloway & Wheeler (2002) identified that it was possible to scrutinize the data from a horizontal and/or a vertical perspective. Horizontal viewpoints concentrated on looking at all the data and identifying themes from it using reflective approaches, and then attempting to find meaning in what could be seen as inconsistencies in that data. An example could be seen in the analysis of the way in which the LPs made the decision to become a nurse. It could be seen that four of the five LPs drifted into nursing; they certainly did not have any particular plan to develop their career in the profession, whereas one LP (Jane) made a deliberate decision to become a nurse as a result of previous personal exposure to the profession and as a reaction to an inhuman and cut-

throat previous career. In contrast, vertical examination sought to dissect sections of the data, such as issues between cases, in order to explore specific meanings or insights within them. An example of this was an assessment made of issues within the background of the LPs and whether this had an influence on what or how they taught students. Note was made of whether their different academic backgrounds had a particular impact on their teaching. It became clear that Ben's and Julie's academic background in biological science had a clear influence on what they taught students and on the importance they placed on nurses having a sound understanding of biology in order to provide a high level of nursing care. Both Eisenhardt (2002) and Holloway & Wheeler (2002) maintained that exploring the data from different perspectives could further illuminate and reveal meanings that would otherwise not become evident. Indeed Eisenhardt (2002) affirmed that:

> 'cross-case searching tactics enhance the probability that the investigators will capture the novel findings which may exist in the data'.
>
> Eisenhardt (2002:19)

At this stage ideas from the analytical memos were considered compared and contrasted with the data in the cases. Similarities and differences in the data in each case were looked for and links were made between categories across the cases. Patterns in the data were looked for and further themes emerged as the analysis progressed. Utilizing ideas from Bassey (1999) a cross case analysis was undertaken to attempt to identify 'fuzzy generalization' (or in a more tentative form 'fuzzy proposition') (Bassey 1999:12-13) from the data across the cases.

As the analysis proceeded it became clear that two overarching themes were emerging; they coalesced around the theme of the nature of nursing and issues around the distinctiveness of the role LPs had within the education of nurses.

The LPs' conceptions of the nature of nursing were highly significant as nursing was the focus of what they taught students therefore it was crucial that their personal understandings of the essence of nursing were made explicit. Within the core theme of the nature of nursing, emerging themes were identified as follows:

- Care
- Communication skills
- Ethical practice
- Creation of a therapeutic environment

Within the text of the cases each of these emerging themes were noted and colour coded (Appendix 2).

Similarly, as the lecturing aspects of their role (and, specifically, elucidating the distinctive role that LPs had within the education of nurses) was one of the aims of the study it was essential to focus on this in the analysis of the data. Within the core theme of the nature of LP professional knowledge further emerging themes were identified as follows:

- Role modelling
- Delivery of teaching
- Elaboration and Guidance
- Reflection

Within the text of the cases each of these emerging themes were noted and colour coded (Appendix 3).

Finally, the notion of trustworthiness in case study research was examined by Bassey (1999) in some detail. He adapted and developed ideas from Lincoln and Guba (1985) and identified areas which he thought were necessary to ensure that 'the ethic of respect for truth in case study research' was given due consideration (Bassey 1999:75). He stressed the need for the researcher to have prolonged engagement with the data, to check the data with their sources, to provide a detailed account of the research and to present a sufficiently detailed audit trail of the study in order to give readers confidence in the findings. The raw data from one of the five completed cases is presented in appendix 4, which provides detailed information as part of the audit trail of the study. Similarly, in order to ensure trustworthiness in qualitative studies, Holloway & Wheeler (2002) were clear that it was essential for the researcher to be immersed in the research setting and to spend time with the subjects and in their environment. In this study, as I was a colleague of the subjects, I had daily contact with them and was fully immersed in the context and setting of the research study. Holloway & Wheeler (2002) also affirmed that tactics such as triangulation, allowing the participants to comment on the completed case, an audit trail and reflexivity would aid verification in qualitative research.

**Ethical considerations**

As the study involved gathering data and information from human subjects it was crucial that ethical principles were taken into consideration at all stages of the project. It was vital

that participants were not subjected to any harm or risk as a result of being involved in the study. In recent years Government departments and professional organisations in health, education and social care have produced guidelines to ensure that practitioners performed research studies in an ethical manner (DoH 2001, World Medical Association 2000, British Educational Research Association 1992). As this study was undertaken in the Faculty of Health within an HEI it was felt that the framework of the four ethical principles identified by Beauchamp & Childress (2001) would be an appropriate guide for the ethical approach to the study. Their work was primarily concerned with Biomedical ethics but the principles were equally relevant to this study in an educational setting. Moreover all the research in the Faculty uses the ethical principles identified by Beauchamp & Childress (2001) to guide their work.

The first principle they identified was that there should be a respect for the autonomy of the individuals involved; this meant that the subjects should make an informed choice about whether to be involved in the study. The purpose of the project was explained in detail individually to the subjects, and they were assured that their participation was entirely voluntary and that they were at liberty to withdraw from the study at any time if they so wished. This information was repeated before each of the interviews and the observation of teaching. The second principle of non-maleficence, which meant avoiding harm to the participants, posed a particular problem in relation to confidentiality. Within the institution each participant could be identified by his or her specialist area of practice and this had the potential to expose him or her to harm. The issues were discussed with each participant individually and notwithstanding the potential problem they all agreed to participate in the study. In the final report, in order to protect the identity of the participants and to ensure as much anonymity as possible, their names were changed.

The third principle of beneficence weighed the good derived from any research against any potential harm to the individual participants. By agreeing to be involved in the research the participants opened themselves up to scrutiny and analysis of every aspect of what was observed and recorded. Notwithstanding these concerns the participants all agreed that the insights that could be derived from the study about the lecturing role of LPs outweighed the possible harm to them. I was mindful of the fact that personal information was asked of participants and I ensured that this information was treated with the utmost respect and confidentiality. The participants were provided with drafts of the case studies and were invited to comment on accuracy and content, particularly if there were any areas or issues recorded in the cases that they would not want to be in the

public domain. These were then removed from the final report.

The final principle of justice was concerned with the fairness and justice of the research strategies employed. Beauchamp & Childress (2001) expressed a particular concern about sampling strategies and the way in which populations represented by the samples are representative of the whole. In this study the sample was a purposive, convenience one and represented the LPs in post at the time in the University College. (Figure 1 p31)

## Summary

Qualitative methods were selected as being the most appropriate approach to address the study aims and research questions which were designed to explore how individuals functioned in their real world (Yin 1994 and Denscombe 1998). Further, case study was adopted as a research strategy with cases being assimilated by building up layers of information from data collected via semi-structured interviews, non-participant observation and documentary sources The cases are presented in the next part of the study.

# Part Three

# Analysis and Presentation of the Cases

## Peter

## Jane

## Mary

## Amy

## Ben

# PETER

## Introduction

Peter is in his early forties and is a LP in haematology and HIV and AIDS. He works as a specialist nurse in a haemophilia unit for two days a week and for the remaining three days he works as a lecturer in a University College. He has recently completed a Post Graduate Certificate in Education (PGCE).

## Biographical details

Peter remembered his childhood with great happiness and thought that his parents had excellent parenting skills. It was not until he talked to other people that 'I realized just how lucky I was with my childhood'. He also enjoyed school:

> 'I was very lucky to have such wonderful teachers that just turned me on to some ideas, particularly from the fifth form onwards. Ideas exploded in my life. There were lots of things that I wanted to do. The main subjects I was interested in were History and Art.'

He developed a particular interest in politics and undertook a degree in Politics and Government. He graduated with an upper second class honours degree and had a place to do post graduate research, but funding for this was withdrawn at the last minute. He had been doing a holiday job at the local hospital and he got to know some of the nurses, who suggested to him that he should think about nurse training:

> 'I thought "well I'll give it a go", so I wandered along to the nurse education centre, asked for an application form. By this time I had hair growing out of every pore. They didn't't exactly welcome me with open arms at the reception desk. They asked me whether I realized that I needed to have some qualifications before I could start nurse training!'

Notwithstanding the fact that he may not have created the most favourable impression, shortly after he was interviewed he was offered a place and started training. He found the system of nurse education very rigid; it was modeled on what he described was an 'archaic school structure'. Within three months of starting his training Peter had not only become his group representative but also the student representative for the whole of the nurse education centre. He was part of a very cohesive and supportive student group, which had an excellent tutor who made all the difference to how the rather poor curriculum was delivered.

Having started nurse training, his motivation to continue was working with people at crucial points in their lives. He found that being able to support and relate to people who were facing illness and life crises was exhilarating as well as challenging 'it's wonderful

working with people on this kind of level doing things for and with people, and it's a socially useful job, so it fits in ideologically'. On his first ward he remembered at least three occasions when a patient died and he realized that 'this was not playing at things'. He also recalled the time when a patient for whom he was caring had a cardiac arrest. The ward sister coped with the situation as an expert practitioner; she moved so fast and so effectively 'she was being a nurse...it was an indication to me that there's a lot of depth in what is going on here its not simply, it's not a normal activity'. He saw expertise in action, he was very impressed with it and he wanted to emulate it. He was also aware of the stress and the psychological cost to the practitioner of working in that expert way. He thought that having to study and develop professional skills and expertise at the same time was more demanding than merely studying full time. He commented that nurse training made him grow up in a very real way:

> 'University was an extension of childhood, nurse training was a maturing process, I don't think it's just about an age thing'.

On qualifying Peter took up a staff nurse post in a ward working with patients who were being treated for cancer. It was an area that he had worked on as a student and for him 'it was the essence of all the things I liked most about nursing, the quality of relationships (with patients) the quality of teamwork the buzz'. It was through working on that ward that Peter acknowledged that he became 'enmeshed' in nursing; 'that's when I became pretty much totally committed to the idea of nursing'.

Within two years he was in charge of the ward and then had the opportunity to work with a specialist consultant in a regional centre looking after patients with haemophilia, many of whom had also developed HIV and AIDS as a result of being given contaminated blood products to treat their condition. At about this time (late 1980s) AIDS and HIV had become a major health issue and Peter became heavily involved with not only caring for these patients but also lobbying for change in the way in which they were looked after and treated by the NHS. He continued to work as the nurse in charge of the unit for several years, during which time he completed specialist courses and an MA in Health Studies. As a specialist nurse he was increasingly being asked to lecture on an ad hoc basis to nurses and other health professionals at a Higher Education Institution (HEI) and a chance discussion with a course leader from the HEI led to him pursue the possibility of a joint appointment as a LP. One of Peter's catch phrases is 'chance favours the alert mind' and it was the chance discussion which led him to change direction in his career and to look towards having a more formal role in teaching as a LP.

**Peter's conception of nursing**

Peter felt that nursing was principally about relating to people; 'the essence for me of nursing is therapeutic relationship'. He was clear that the nurse should have a psychodynamic relationship with patients, combined with technical knowledge and skills. He stated that he had a reductionist approach to looking at this; he felt that if the quality of the relationship was removed technical skills were all that was left and nurses were much more than technicians. 'If they don't have a relationship they are not nurses.' However, equally, he commented that the relationship on its own was not enough; technical skills were necessary for healing interventions to take place. He described himself as a psychodynamic nurse and he clearly identified that the nurse-patient relationship was of paramount importance.

Peter's radical and very strongly held political views led him to be passionately concerned with people, particularly those who were vulnerable or in some way outcast from society. His work with patients with HIV and AIDS epitomized this and had a deep effect on him; the personal and professional satisfaction of working in that situation was profound. 'The ward that I worked on and the people I worked with, I am just so proud of being part of that.'

**Peter's principles of practice as a lecturer practitioner**

Peter had developed principles for practice as a lecturer from several years of working as a LP and from having done a PGCE. His principles for practice are summarized as follows:

- to prepare and support student and practicing nurses in their educational needs
- to provide students with cognitive and affective aspects of knowledge they require for excellent clinical practice
- through being a practicing nurse, to be a role model for students
- through education, to prepare students to be thinking practitioners who would be able

to be advocates for their patients.

Peter firmly believed that nurses must be able to assess the evidence underpinning service delivery so that their care was based on rationality not ritual. His role as a LP enabled him to reflect the reality of the day-to-day dilemmas in practice using illustrations and scenarios from actual practice.

Peter had a facilitative style of teaching and he encouraged students to participate in and contribute to his sessions. He appeared to have a very open relationship with students and when they contributed or asked questions he always responded in a positive way even if this meant that the session moved away from his original plan. He was keen to provide students with appropriate physiological knowledge and it was clear that he had a very extensive understanding of the complexity of human physiology. Within his teaching he constantly related specific physiology to symptoms of disease or specialist diagnostic tests, in this way linking theory with practice.

Peter was also most concerned to challenge students about their preconceptions about diseases which people might view as socially unacceptable, notably HIV, or issues which nurses might not wish to address, such as sexuality and older people. He used discussion backed up with epidemiological evidence as a teaching strategy to assist students to look at some of these issues. He also used small group work as a way of facilitating discussion about issues which students might feel ambivalent or uncomfortable about discussing in a larger forum. These strategies were a way in which the affective area of knowledge could be explored and re-appraised. Peter's frequent reference to practice and to the uncertain and difficult conditions within which practitioners functioned indicated that he had a current and real understanding of the issues. He could be seen as a role model for students in that he as a practitioner struggled to deliver high quality care to patients himself, based on research evidence and therefore he understood how difficult it could be for them.

**From principles to practice**

Two teaching sessions were observed and tape recorded, and detailed ethnographic field notes were made of them. The first session was with a group of fourteen qualified nurses who were studying for the specialist course in cancer nursing. The second session was with a group of twelve qualified nurses who were studying for a specialist course in the care of the older adult. Both sessions took place in well equipped lecture rooms, which

provided all the facilities necessary for teaching post registration nursing students.

**First session: Immunology (using HIV as an exemplar)**

Peter introduced the session and explained what he aimed to cover, how it linked with what they had covered in the programme already and how it might link with future sessions. He was joined in the session by a LP colleague who had recently come into post. The students were undertaking the programme for which Peter had personal responsibility and in which he did most of the teaching. It was the eighth session of fifteen in this part of the programme, so he and the students knew each other quite well. There was a considerable amount of good-natured banter between Peter and the group; however there was never any doubt as to the fact that he was leading the session. At the outset he invited students to ask questions about Immunology as well as HIV/AIDS. One student asked 'Is HIV/AIDS still on the increase?' Peter answered 'Yes it is' and he elaborated on the answer by using information from an acetate he had showing routes of transmission of the virus and the most recent information about the safe sex message, with possible explanations as to why it is or is not being heeded. He then discussed patients who might be in units the students were working on and who would be being treated for cancer which they had contracted as a result of being immunocompromised by HIV. Peter then initiated a brief discussion about international and national variations in relation to the incidence of HIV. He discussed examples of incidence of the disease: for example 60% of all cases in the UK are in London and in the Ukraine something like 80% of IV drug users now are HIV positive in contrast to 2% positive about seven years ago.

Peter then revised the physiology of how HIV affected the immune system. He drew diagrams and charts on the large whiteboard at the front of the classroom using the whole of the board whilst talking about the detailed physiology. The students commented at times, but by and large they listened and made notes about macrophages, T4 cells immune system and T8 cells. They all appeared to be fully engaged with the session as they made notes and verbal contributions. He continued to expand the physiological illustrations whilst interacting with the students and encouraging them to contribute. He darted around the front of the room making points from his first diagram on the board in conjunction with the flip chart; the students laughed and bantered with him. His physical activity in the classroom as he made points emphasized his interest in the subject, underlining its dynamic nature and the rapid progress that had been made in the treatment and management of the disease over a very few years. The students continued

to ask questions, particularly in relation to how HIV could affect their own patients; for example there was a discussion about the dangers of using human sources for vaccine production. Peter continued the session by explaining in detail how HIV attacks the immune system, linking the physiology with symptoms that may be evident. He also explained how viruses might cause cancer and how the immune system is affected in this. He continued to expand in detail the mechanism of the replication of the HIV virus with the aid of a further diagram and a handout; he explained what clinical markers were; the students made notes on their handouts. One student asked 'Can the HIV virus live outside the body?' Peter responded 'It can, it depends on how you look at it. The vast majority of infective material will only live for half an hour'. They discussed the hazards of occupational exposure and of the best way to deal with things like needle stick injuries. Peter commented that 'most occupational health departments have a cocktail of three drugs that can be given to try to avoid accidental injury from resulting in infection with the HIV virus'. He outlined from the diagram on the whiteboard how the drugs worked, and why they had to be taken as soon as possible after exposure to the infection, and, if possible, within half an hour.

As the session continued Peter discussed recent treatments and management of the disease, and compared treatment in the developed world with that in the developing world, where HIV is a major health problem. All the time he linked the diagrams on the board and flip chart with information about the latest treatments and the mechanism of the progress of the disease; he also discussed the history of HIV and the current situation as to the mode of transmission.

There was comment and discussion about what people with HIV/AIDS actually died from, as death is caused not by the virus but by other conditions (including cancer), which the patient developed as a result of a compromised immune system. Peter explained that the diagnosis of AIDS was only made when the patient was HIV positive and had one or more of twenty six identified illnesses.

The discussion led by Peter moved on to consider the social results and implications of HIV, issues such as the 'gay plague', and there was an animated discussion about how governments proposed to deal with people who were HIV positive when the disease was first seen. There was discussion about so called 'leper colonies' for AIDS. There was a very lively discussion about the rights of patients with HIV and how society and the health care system should treat them. Ethical issues in relation to the testing of people for HIV

were discussed as well as issues of consent and patients' rights in relation to informed choice and counselling before testing. Practice related concerns were raised by students, for example the need for strict adherence to taking universal precautions when looking after any patients. The issues of false positive results from testing were discussed and Peter explained how this could happen by showing diagrams on the board and the flip chart. The session concluded with an exposition about recent innovations in the treatment of the disease, illustrating this with reference to survival rates now in comparison with five years or more ago. He discussed the fact that there were now at least 20 different drugs on the market for the treatment of HIV /AIDS. The fact that these drugs were powerful and may have untoward side effects was also discussed. Peter briefly reviewed what he had covered in the session and he invited further questions. As the students left for their tea break they were all discussing the session and commenting about how it had related to their practice.

**Second session: Sexual health in old age**

This session was with a group of twelve post registration experienced nurses who were undertaking a specialist post registration programme in the Care of the Older Adult. Some of the students worked in hospitals in the NHS but several of them worked in privately run nursing homes. Peter had not met the students before and it was the ninth session of fifteen on the programme.

Peter introduced himself to the students and outlined what he intended to cover in the session. He started by presenting some statistics about the incidence of sexually transmitted diseases, including HIV, in older people and he asked the students whether the incidence of disease was what they would have expected. Generally the students indicated that sexuality was an issue in the care of older people that they did not think about very much.

Peter then asked the students to get into four groups and to work together for ten minutes on some case study scenarios. Peter circulated around the groups, he facilitated discussion and encouraged students to explore the issues.

Peter had discussed the scenarios with me before the session and stated that he had a deliberate strategy through the case studies to get students to identify for themselves what information they needed to have for their own practice.

The students then started to give feedback from the case studies and Peter made notes of

the salient points on the whiteboard. At first the students did not realize that the four case studies, which were free standing, fitted together to form one overarching case. This became apparent as they gave the feedback on the scenarios. As the students saw that their case was part of a larger picture other issues emerged for discussion specifically relating to their own practice, for example: legal issues, issues of consent and possible sexual abuse of vulnerable older people, confidentiality and ethical issues. These were all discussed at length by the group, led and guided by Peter, who provided appropriate information as necessary, for example about legal issues or the ethical context of care. One student asked 'I just wonder where confidentiality ends with HIV, how long do you have to keep confidentiality?' Peter responded by saying 'That is a very difficult thing to answer because there are some legal guidelines but there are also some very big grey areas... where does the responsibility to the individual stop and responsibility to a larger group take over? And I think that the simple answer is that there is no clear line, it has to be dealt with case by case'.

Peter then led the discussion on to consider wider issues, such as normal sexuality and older people, challenging some popular myths and stereotypes. The session moved on to look in greater depth at issues related to practice such as whether institutions and those working in them could and should facilitate sexual activity for their residents. Peter also presented issues in relation to consent to sexual activity by looking at local and national guidelines and legal definitions. There was some animated discussion about this in relation to HIV and sexually transmitted diseases and how public health concerns could become an issue for those running and working in residential homes.

The last part of the session was taken up with students asking Peter general questions about sexual health and HIV and AIDS, particularly issues about mode of transmission of the virus and recent developments in the management and treatment of the disease. One student asked 'Could you explain the process from being diagnosed as HIV positive to being diagnosed with AIDS?' Peter replied 'Yes' and started to draw a diagram on the whiteboard. 'I am not very good at it but I like drawing!'; the students laughed. He illustrated the clinical markers that were seen in HIV and the progress to being diagnosed with AIDS. He continued to answer students' questions, using the whiteboard to illustrate the answers. The session concluded with Peter commenting that he hoped the students had found the information useful and wishing them well in their studies.

**Summary**

Peter came into nursing having done a degree in politics and government; he felt that it was a socially useful occupation and he found it an absorbing, stimulating and rewarding career. Following qualification he was promoted quickly and spent most of his clinical practice working with patients who had HIV and AIDS. He strongly believed that nursing was primarily about relating to people. However, it also required a high level of technical knowledge based on a deep understanding of the physiology of health and disease. His work with patients with HIV and AIDS convinced him of the need for nurses to act as advocates for their patients in order to be able to provide the high level of care that was necessary.

As a LP Peter understood his role to be to support students in their educational needs principally by making links between theory and practice. He did this through enabling students to develop a thorough knowledge of the physiology of disease and from that to be able to understand patients' requirements for nursing care. He had an open interactive style of teaching and expected students to contribute to the sessions. He asked for questions or comments from students and if necessary varied the pace of sessions to suit students' needs and understanding of the issues being considered. As a practitioner he acted as a role model for students and was constantly able to relate issues from practice to his teaching.

**JANE**

## Introduction

Jane is in her mid thirties and works part time as a lecturer in Coronary Care Nursing and Clinical Science. She recently completed a Post Graduate Certificate in Education (PGCE) and has started an MSc in Interprofessional Health and Community Studies. Recently Jane returned from maternity leave and started to work part time in order to balance the demands of family life with her career. Before taking maternity leave Jane worked full time as a LP in a coronary care unit and in the University College.

## Biographical details

Jane was born and grew up in a small town in South Wales. She had what she described as a normal happy childhood; the only shadow was the several periods of unemployment her father experienced and she recalled the feelings of anxiety and stress that this caused for all the family. When she was at university her grandfather became terminally ill; her neighbour nursed him in hospital. This event had a profound impact on Jane and ultimately influenced her career decision. She commented:

> 'seeing as she (the neighbour) cared for him and how comfortable he was, and what a good death he had, it sort of touched me. I think that, you know, the role that nurses could potentially have'.

It was clear that Jane had been greatly impressed by what she saw of nursing and she realized what a difference 'good' nursing made to her grandfather in the final days of his last illness.

She graduated from university with an upper second class honours degree in Biological Science and obtained a job in marketing/sales in London in what she described as a 'high pressured cut throat environment'. She missed the contact with biological science, which had been her great interest, and she became more and more disillusioned with the work. When after two years she was made redundant she grasped the opportunity to change her career. She decided that she wanted to 'do something more human', to work with people in a more caring environment. It was then that she recollected how well her grandfather had been looked after and she resolved to train as a nurse. Jane felt that nursing was the antithesis of what she had been doing in sales and for her it was a 'revolt

against the inhuman and impersonal world' that she had been part of.

Following her training Jane worked on a medical ward as a staff nurse, which also had a coronary care unit attached to it. As a staff nurse she particularly enjoyed contact with students and thought that ultimately she would like to develop her career as a nurse teacher. In spite of her relatively short time in clinical nursing, three years ago she was successful in her first application for a post as a LP in coronary care nursing at a University College.

**Jane's conception of nursing**

Even though Jane has had a relatively short clinical career she had clearly formulated ideas about the nature of nursing. She believed that it involved a level of technical competence (this was congruent with her background in the biological sciences) and that nurses should have a deep understanding of the natural sciences and this allowed them to create a professional environment. She declared that for her nursing meant that :

> 'You are there for the patient to be relied on as the main point of contact; you are able to give them what they need in terms of physical care. Patients look to you to do what is right for them'.

She also identified the caring aspect of nursing, in particular a willingness to become involved with patients. This meant that nurses must develop excellent interpersonal skills in order to be able to communicate effectively with a variety of people: patients, relatives, colleagues, doctors etc. She commented that for the time the nurse had with the patient, and to some extent their family, she was one of the central people in their lives. In support of this she claimed 'nursing means connecting on some human spirit level with patients; you are able to touch and influence the lives of the people you are caring for'.

It was clear that she placed great importance on both the technical rational and on the interpersonal elements of professional competence. This holistic approach to nursing care was exemplified further in her comment that 'nurses should be relied on to do what is right for the patient', which involved 'nurses touching people physically, emotionally and connecting on some form of human spirit level'. She commented that sometimes there could be a very intense relationship between the patient, their family and the nurse. However, more often patients' needs were more mundane and the relationship was less demanding, for example emptying a catheter bag or fetching the telephone. 'It's a simple job, but for them that is something that is quite important; they've asked you for something that they need and you've met that need for them.'

Jane's ideas about nursing have emerged from her own experience and crucially from working with other nurses and observing how they worked. She stated that her ideas had been developed by:

> 'looking at nurses that you respect and you see how one nurse acts with a patient and you think; "that was really good that's how I want to be".

One of the people who had been a very positive role model for her was the ward sister she worked with when she was a senior staff nurse on the coronary care unit.

However Jane also commented that:

> 'sometimes you can learn just as much (about nursing) seeing someone who has left that patient in a real mess, or has handled a situation that I think "well you haven't, you've not done them any favours here".'

As she further stated 'it's about positive and also negative role models, which are probably as strong'. This indicated that she believed that both positive and negative images of nursing influenced her own thoughts and ideas about the nature of nursing.

It became clear that Jane's conception of nursing had four key elements: technical competence (from knowledge and experience), physical care, emotional support (which involves being there for the patient), and connecting with the patient (and their family) on some form of human spirit level.

**Jane's principles of practice as a lecturer practitioner**

From her three years experience as a LP as well as from the Post Graduate Diploma in Education (PGCE) Jane had developed clear ideas which underpinned and informed her practice. From the interview data it is apparent that these principles of practice coalesced around the key areas summarized as follows:

- to provide students with the building blocks of scientific and technical knowledge they required for practice
- to encourage students to take ownership for their ongoing professional learning needs
- through education and the development of reflective practice, to enable students to change practice and to improve patient care
- from current clinical practice to select appropriate case based material to illustrate and illuminate her teaching.

At the outset Jane aimed to provide students with knowledge and information in the form

of building blocks to inform and underpin their practice. She asserted that the knowledge and information that she was mainly concerned with was rooted in clinical science. She saw this knowledge as forming the foundations of the professional knowledge student nurses needed to function effectively in practice. Furthermore, within their educational programme the application of this knowledge to practice emerged gradually as students were exposed to practice over time.

Jane always sought to encourage students to identify what further knowledge, skills and understanding they needed to develop for their continuing professional development and learning in practice. As she noted:

> 'In the light of the knowledge that maybe I've given but also the knowledge I've hopefully, you know, prompted them to think of or facilitated them to seek'.

She hoped that by enabling students to develop ownership of their learning they would identify their own requirements for professional development, an ongoing process. She realized that she might only be a small part of that process as it would require each nurse to formulate and negotiate their own learning path in the light of their particular practice. She declared that:

> 'hopefully at some point that information, that bit, will link up somewhere, but it may not be linking directly through me, I'm hoping they are going to pick it up at some other point and use that knowledge then in a meaningful way to practice'.

Each student would have to make their own connections about what forms of knowledge they required for practice and it would be the student who pulled it all together for meaning into their own practice.

Jane also hoped to change and improve patient care through the teaching of new knowledge skills. She affirmed:

> 'I think that's what I'm aiming to do is to hopefully make things, again it might sound a bit clichéd saying it, but it's about making the difference to patients... hopefully what they are learning is going to impact what they do, it's going to influence how they deal with things or how they work as nurses'.

Jane was convinced that her recent experience of clinical practice enabled her to bring relevant real life issues to her teaching. She felt that this was particularly important when she was teaching the post registration courses to experienced nurses. She stated that her clinical background:

> 'allows me to I suppose pick out those areas that information or what I'm teaching to pick out those areas that are going to be directly relevant to that, so I think in terms of content. It will have an effect, so I think that what I give is that, is that specialist knowledge which at

> the end of the day comes from adding current practical knowledge and I think that without that certainty, the very clinically based courses like the coronary care course I think that the, if taught by somebody who wasn't as current as myself in clinical practice, I think the quality of that course would be worse'.

She made an impassioned argument for the case for LPs' expertise in clinical nursing practice as an essential requirement for teaching on clinical courses. She was able to select relevant clinically based material to illuminate her teaching. For example when she taught the coronary care course about atrial cardiac arrhythmias she used examples of actual Electro Cardiogram (ECG) tracings of arrhythmias from patients. She emphasized the fact that coronary care and cardiac nursing was a highly dynamic area of practice which was constantly changing, and she was able to draw on materials from current practice as treatments changed and developed rather than having to rely on books and other secondary sources, which would inevitably not be as up to date.

**From principles to practice**

Two of Jane's teaching sessions were observed; tape recorded and ethnographic field notes were made. The first session was with twenty pre-registration students on the Diploma of Higher Education in Nursing and the second session was with six qualified nurses who were undertaking the specialist Coronary Care nursing course. Both sessions took place in a modern lecture room, which provided all the equipment necessary for teaching nursing students.

**First Session: The physiology of the locomotor system**

This was taught to a group of twenty nursing students as part of a clinical science module at the beginning of the first year of their three year Diploma of Higher Education programme. It was a formal teaching session with Jane providing information to students about the normal function of muscles and joints. One of the main issues Jane identified in the groups was the variation in range of ability and of experience of study of the students, and of the problem that posed for the lecturer. She had the challenge of maintaining the interest of those who already had advanced knowledge of the subject while at the same time not proceeding too fast so that the novices were left behind, with the danger that they became confused and anxious. Jane commented that :

> 'there are some people with A level biology and some people who have never done it before, or worse than those who have never done it before are those who have done a little bit before and have failed and now have this big fear about the whole thing'.

Jane employed various strategies to overcome these problems, the first of which was to

start the lesson with a quiz based on the subject covered in the previous session. This gave immediate feedback to students and was a positive reinforcement to them.

The session was mainly teacher led but interactive and was concerned with giving students information about the anatomy and physiology of the locomotor system. She continued the session by looking at bones and the skeleton, illustrating points on the flip chart and overhead projector. Jane asked students questions and encouraged them to ask questions of her. An example of this was that she asked 'What is a ligament?'. A student answered 'they attach muscle to bone'. Jane replied 'ligaments actually attach bone to bone'. The question and answer strategy enabled students to develop their knowledge from the known to the unknown. An incomplete handout for students to fill in as the session progressed supported this strategy.

They then considered different joints, muscles, ligaments and tendons, their function and action. Jane asked 'so which ligament does Gazzer have a problem with?' A student answered 'cruciate ligament'. Jane said 'yes' and asked 'where in the body is the cruciate ligament?' A student answered 'the knee'. Jane agreed and then explained that it was called the cruciate ligament because it was cross-shaped. The session then explored movement, which required joints, muscles and bones to work together. Issues such as balance and co-ordination and the detail of how the nervous system worked together with the musculo skeletal system to facilitate movement were discussed.

Jane then demonstrated flexion with a volunteer by moving his arm and reducing the angle of the joint. She asked 'What is the angle of this joint here?' The students answered '180 degrees'. She then moved the volunteer's wrist 'and now here?' The students answered '90 degrees'. Jane then said 'flexion is to reduce the angle of the joint'. Jane then continued to demonstrate various movements with the aid of the volunteer and with OHP slides, giving the technical terms and degree of angle of movement. The whole process was accompanied by hilarity and comment from the students and it certainly engaged them in the learning activity.

What they had seen was followed up with further handouts about movement and moveable joints. There was considerable discussion about how understanding the physiology could affect the practice of nursing. The safe moving of patients was a major point. In a humorous way Jane illustrated this by asking students to consider the concept of stability in relation to whether a mouse or a giraffe had the more stable base and how this concept could be applied to how they moved patients in practice.

At the end of the session Jane suggested further reading activities and open learning materials that students could work through to follow up the information she had given them.

**Second session: Atrial arrhythmias**

This lecture was to a group of seven experienced post registration students who were undertaking a specialist course in coronary care nursing. They were near the end of the first part of their course. The session was teacher led but students were expected to interact and contribute to the session. Jane started by providing a handout with different Electro Cardiogram recordings on each sheet. The lesson was structured around the information on the handout. She asked the students to identify the recording on the first sheet and to give their reasons for their diagnosis. It was of a very simple ECG tracing showing normal sinus heart rhythm and all the students identified it easily. From the next tracing Jane asked 'What's going on there? any ideas?' The students looked blank so Jane said 'You know the session is on atrial arrhythmias so that gives you a bit of a clue'. A student said 'sinus rhythm with atrial ectopics'. Jane said 'It **is** sinus rhythm with atrial ectopics. How did you know, how did you work that out?' The student responded 'Erm well if you take away the atrial ectopics you would have what would be a regular sinus rhythm with all the characteristics of a sinus rhythm'. Jane responded 'right' and nodded her head. The student continued saying 'but you are getting these extra premature beats coming in which are er well initially a different shape to the sinus rhythm'. Jane again responded 'right, O.K.'. The student continued 'and they are causing it to become irregular because of a pause after it'. Jane agreed with the response and summarized the main points that the tracing showed. She discussed the normal cardiac cycle seen on an ECG tracing and how premature ectopic beats could be identified. She challenged the students to provide the evidence on the tracing for their diagnosis and a general discussion ensued about how information could be seen on tracings. Jane then moved the session on to look at more complex recordings each of which was discussed at length and issues were explored in relation to treatment as well as diagnosis of conditions. It could clearly be seen that Jane moved the students on from simple concepts to the more complex. This was clearly a pedagogical strategy to encourage students to explore concepts and issues more deeply and thereby to develop a fuller understanding of the material. As each

condition was discussed Jane outlined, with the help of OHP slides, the detailed physiology. She encouraged the students to discuss patients they had come across with conditions that were identified and to think about how and why they had been treated in a particular way or with a specific drug. She thus enabled students to make connections between the physiology of specific cardiac conditions and the practice of nursing patients with cardiac disease. She clearly provided an arena for discussion and the opportunity for students to reflect on practice in the light of new or revised knowledge. She used case based material to explore the application of physiological knowledge to practice. For example she discussed her own experience of looking after a patient with Wolff Parkinson White syndrome (WPW). She asked the students 'What is the main way in which patients with WPW are managed?' A student responded by saying 'ablation'. Jane agreed and said 'most patients with WPW what will happen is they will surgically ablate this pathway (indicating the pathway on the OHP slide); end of story, no more problems. What could be a complication of that?' A student responded by saying 'pacemaker'. Jane agreed and explained by drawing a diagram on the flip chart 'If you have got your pathway quite close to your A.V. (Atrio Ventricuar) node here the chances are that if you are taking out this bit of tissue as well the whole thing goes, so you will need a pacemaker'. She outlined how the patient she had nursed presented and was actually treated in practice as well as discussing different treatments that might have been used.

Throughout the session Jane was able to demonstrate her current knowledge of clinical practice by quoting examples of the use of specific drugs in practice and of specialized treatments for cardiac conditions.

**Summary**

Jane came into the nursing profession having done a degree in biological science followed by a high powered sales job for two years. She found that nursing was a contrast to the cut throat environment and provided her with more personal job satisfaction.

She had clear ideas about the nature of nursing. She believed that nurses needed to have a thorough understanding of normal physiology and of the way in which disease and illness affected the human body. She also proposed that nurses should care for patients and connect with them on some form of human spirit level.

As a LP Jane aimed to provide information in the form of building blocks of theoretical knowledge for students so that they would understand the physiology of illness and

disease and therefore be able to look after patients in an intelligent way. She had an interactive style of teaching and expected students to contribute to sessions by reflecting on their own practice and personal experience. She used her own recent nursing experience to illustrate her teaching sessions, particularly those with post registration students.

**MARY**

## Introduction

Mary is in her late thirties. She is a LP in surgical nursing. For two days a week she is attached to a surgical unit in a local District General hospital and for the remaining three days she works as a lecturer in a University College. She has recently completed a Post Graduate Certificate in Education (PGCE).

## Biographical details

Mary was born in London and brought up in Surrey. She was the second daughter and the youngest of three children. Her mother was a nurse and her father was a policeman. Mary did not really know what she wanted to do for a career. She felt that she wanted to do something that would give her a measure of independence and security. She therefore decided to apply to train as a nurse as soon as she could. She declared:

> 'To be honest I didn't know what else to do, I had no idea what to do and it was in the family, and that it was that I had to do something with my life... I sometimes look back and think, "I wonder if somebody had encouraged me to go on to university, maybe I would have done something different"... you do sometimes wonder what else you might have been capable of.'

She thought that she was subject to a certain amount of gender stereotyping and that both her school and her family had the attitude that nursing and teaching were suitable careers for girls and that medicine and dentistry were for boys.

She didn't really enjoy her nurse training but she did feel that it enabled her to develop and mature personally as well as professionally. She commented 'it gave me a lot of insight into people, I think, and maturity.' She certainly enjoyed the social life and she was part of a very supportive group which had an excellent tutor, who Mary said 'kept us on the straight and narrow'. She found that she enjoyed looking after people even though she did not feel that she had a 'vocation' to be a nurse.

Following her training she had what she described as 'reality shock', and felt that nursing was not what she had expected. So she left the profession to travel the world for three years. When she returned to England she got a job in an Intensive Care Unit (ITU) and to her surprise enjoyed the work. After a few months she heard about a new part time degree programme for qualified nurses, which the local Higher Education College was running. She said

> 'I looked at the ad. and thought, "yes I'd quite like to do that". It suddenly occurred to me

> that I should go to university or whatever and do a degree, so I went straight into my nursing degree'.

Over the next few years she worked as a staff nurse, initially on ITU and then on a gynaecology unit. She found she really enjoyed the teaching aspects of her staff nurse's role. She thoroughly enjoyed studying for her degree and indeed described herself as being 'hooked on study'. So, almost immediately after finishing her first degree she started a Masters degree. Mary felt that doing a degree was a highly significant event in her professional life. She declared that 'doing my degree did give me a lot of confidence and opened my eyes to things'. She felt that much of what was done in terms of patient care was based on tradition and ritual with very little questioning of the rationale of the care being given to patients. She was able to integrate the knowledge she gained from her academic studies not only with the care that she gave to patients but also how she taught students and managed the ward.

When she finished her Masters degree she decided to progress her ideas about moving into education and applied for her current post at the University College as a LP.

**Mary's conception of nursing**

From several years as a practising nurse and from studying for two degrees in nursing Mary had developed her own personal concept of the nature of nursing. She was clear that nursing was about caring for people, but she felt that it was more than just providing physical care. It was about providing a service for people, which was what she described as the modern form of care. She felt that nursing was the co-ordination of the whole service for individuals. Illustrating this idea she declared that the sort of thing that she would say to a patient would be:

> 'Right, I'm here, I'm your nurse. I'm here to provide for you, to look after you, to make sure your stay with us, if you like runs smoothly, that you get everything you need, that your appointments are kept, that you get your investigations that you require, that you get the treatment that you need on time'.

She felt that the attention to detail in relation to what patients needed when in hospital was a crucial part of nursing care. For the patient it was often the apparently small and what might be seen as the insignificant things that they remembered about their stay in hospital. For instance whether their questions were answered in ways in which they could understand or whether they felt that the people attending to their most basic needs treated them with dignity and respect. Mary also felt that it was vital that patients had confidence in the people looking after them. To illustrate this she related an incident from when she

had recently been in practice. A patient for whom she had been caring commented that she (Mary) 'gives the impression of being the one who knows, who's in charge and has got the finger on the pulse'. Without being conceited Mary found this comment gratifying and thought that it was just what she wanted to present to patients. She explained that sometimes she had worked with students who, because they themselves were novices and lacked confidence, were not able to provide the ambience that patients needed. She had been able to put the patient and the student at ease. She illustrated this by saying 'you put your hand on the patient's hand and say it's OK, you know, and you almost feel them relax under your hand and you know that they have got confidence in you'. Mary felt that excellent communication skills were part of relating with patients and an essential component of good nursing care.

**Mary's principles of practice as a lecturer practitioner**

From three years as a LP and having studied for a PGCE, Mary has developed clearly formed ideas about the practice of nurse education and her role in it. The key issues she identified were as follows:

- to produce knowledgeable competent practitioners by teaching the principles of specific aspects of nursing care.
- to foster self awareness and an attitude of life-long learning in students so that care was and continued to be, based on best possible current evidence
- to nurture and encourage students to continue to develop professionally and to influence and change practice
- as a practising nurse, to be a role model for students

Mary's understanding of the way in which her educational experiences shaped her own practice gave her the impetus in turn to influence students herself. She was clear that nurse education was a very practical form of education and that it should and could affect the way in which nurses provided actual patient care. She had been able to challenge traditional ways of delivering care to patients and thus to change not only her own practice but also the practice on her ward.

A major feature of the way in which Mary functioned as a LP was to encourage students to make the links between theory and practice and to change practice. She commented that

> 'sometimes they just need somebody to say, "it's OK what you are doing, you know, keep at it and you're doing things well", and it's very sad they don't get that in practice.'

She was very committed to the notion of professional development and she saw her role as someone who enabled students to critically review their practice and to identify what they needed from education in order to continue to function as effectively as they possibly could. She declared

> 'if every student nurse that we produce as a practitioner, if they think they've got everything they need for the rest of their professional lives, they are badly deluded'.

As a role model in practice Mary was able to illustrate her teaching from real life current situations. She could say to students 'I was caring for this patient yesterday or last week, this is a real example from real life'. She argued that this ability to reflect on and use illustrations from practice gave her teaching a freshness and vitality that was very much appreciated by students. She was also sometimes able to work on the ward with students she had taught and she found this particularly rewarding:

> 'for me it's kind of like putting everything together; its like saying, "you know, remember we talked about this in the classroom"'.

**From principles to practice**

Two of Mary's teaching sessions were observed and detailed ethnographic field notes were made. Both sessions were with post registration students who were qualified nurses undertaking further specialist study. The first session was a workshop and it took place in a teaching room in the premises of an acute hospital trust. The room was adequately equipped and had video and overhead projecting facilities; however it was rather shabby and all the equipment was old and worn. In contrast, the second session took place in a modern well equipped teaching room in the university college premises, with overhead and video projector and all the latest equipment necessary for teaching nursing students.

**First session: Clinical supervision workshop**

The three hour session was taught to a group of three students. It was the last of a series of workshops developed by Mary specifically for the NHS Trust in order to prepare for the implementation of clinical supervision in all areas during the next year.

Mary introduced the session and confirmed that it would be informal and she would welcome contributions from any of them at any time. She invited the students to introduce themselves and asked them to state whether they had any experience of clinical supervision. One student stated that she had been on night duty the previous night and

had not had any sleep since then (the session was from 1pm to 4pm!) so she would try to stay awake.

Mary started by considering definitions of supervision and asking for students to contribute their own ideas. She wrote key points from the students such as 'supervising' on the flip chart. They discussed examples of what each point meant in practice. The session moved on to consider the definition from the nursing professional body of the term 'clinical supervision'. Mary then led a discussion comparing and contrasting the concepts of mentorship, preceptorship and clinical supervision. She affirmed 'We never stop learning or needing support at work to develop good practice'. Mary then explored with students why clinical supervision was an issue in health care at the present time. She and the students agreed that the Government's recent emphasis on the concept of corporate responsibility, accountability and clinical governance in health care delivery was the major factor. Clinical supervision was seen by NHS managers as a way of empowering staff to provide a high standard of care to patients. They explored how clinical supervision was a way of developing self awareness in individual practitioners and of how colleagues could be constructively challenged to change and develop practice. They agreed that clinical supervision provided both support and challenge for practitioners. The session moved on to consider different ways in which clinical supervision could be undertaken. Each approach was discussed in detail and the advantages and disadvantages explored. The issue of who would be appropriate as a supervisor was also explored and the problems that might be encountered when the supervisor was a line manager. The differences between clinical supervision and annual individual performance review, which was a line manger's role, were examined. The session moved on to contemplate legal aspects of clinical supervision, patient confidentiality and whether clinical supervision was cost effective. Mary discussed the benefits of clinical supervision in terms of a reduction in sickness rates, which could be measured, and raised staff morale, which could not so easily be quantified.

The students then had a coffee break for half an hour before restarting the session.

The student who had been on night duty was obviously very tired and kept yawning but she appeared to be slightly more refreshed after the break.

Mary restarted the session by reviewing what had been covered in the first part. She stated that she would like to consider in more detail the issues in relation to the implementation of clinical supervision in each student's clinical area. She asked them

'what are your ideas about the implementation of clinical supervision?' One student answered 'people do not have time or the inclination to implement it'. Mary asked 'Why is that?' Another student responded 'because they do not know about it'. The discussion then moved on to look at how the positive aspects and benefits of clinical supervision could be communicated to other staff. Mary emphasised the need to change the culture of the ward environment so that all staff would be see the benefits of clinical supervision. Mary then moved the session on to look into the responsibility of the person being supervised to prepare for the supervision session and whether supervisor and the person being supervised got on well and mutually felt that the supervision was beneficial. The issues of whether it was seen as a priority and something that staff supported each other in, and covered for each other if necessary, was discussed.

Mary then showed a short video clip about the different ways in which clinical supervision could be undertaken. The students then had a lively discussion about how some of the issues shown in the video could be applied to their own practice. Mary then provided a handout of a model of structured reflection and discussed with them how this could be used in practice. Finally she led an exercise about what sorts of things could be discussed at a supervision session and how to prepare for it.

Mary then brought the workshop to a close by reviewing what had been covered in the session. She asked for comments from the students, thanked them for attending and asked them to complete an evaluation form before they left.

**Second session: Management of pain in patients in acute care settings**

This session was with six post registration students who were undertaking a specialist programme in critical care nursing. The students were experienced nurses all of whom worked in the NHS in acute hospitals throughout the region. It was the tenth session of fifteen in the programme. Mary knew the students well as she had taught them for several of the previous sessions.

Mary introduced the session and outlined what she aimed to cover. She explained that the session would revise the physiology of pain and look at ways of managing pain. She started the session by revising neurophysiology, starting with nerve transmission. Mary used the whiteboard to draw a nerve cell and talked through the structure of the cell and the way in which impulses were transmitted from a nerve to the central nervous system. She questioned the students about neurophysiology and she quickly realised that the

session would have to concentrate on developing the students' knowledge in relation to physiology rather than merely being a revision session. Using the whiteboard, overhead projector and an expository and questioning approach, Mary clarified anatomical terms such as 'Schwann cells' and 'Nodes of Ranvier'. The sodium and potassium pump, the role of electrolytes and the action potential were also explored in detail. Mary then moved on to explore the link between the physiology of the nervous system and pain. She asked the students 'What is pain?' The students responded in unison 'What the patient says it is'. This was a definition from McCaffery (1999), which was commonly used in nursing practice. Mary agreed and presented other definitions for the students to think about. They discussed the differences between a medical definition and nursing definitions. Mary emphasised the nursing definitions as those which took an holistic approach to why a patient might say they were in pain. One student raised the issue of how to deal with patients whose pain might not be 'real'. Mary and the other students challenged her about this idea and a general discussion ensued about whether nurses or other health professionals should make objective judgements about what is the subjective experience of being in pain. The discussion looked at issues such as whether patients might become dependent on narcotic drugs or whether some patients might need to be referred to a pain specialist. Mary suggested that nurses should consider alternative means to relieving pain rather than always assuming that patients needed narcotic drugs. One student commented, 'I don't think that we do that enough do we?' Mary and the other students agreed. Another student described how he had seen effective pain relief strategies with self-administered entonox being used. They then looked at other forms of patient administered pain relief or Patient Controlled Analgesia (PCA) and the fact that when the patient has control of their own means of pain relief they actually require less analgesia. They briefly discussed the psychosocial aspects of pain and pain relief and the issues of patient support and empowerment. Mary moved the session on to explore the gate theory of pain as defined by Melzak & Wall (1991). This required students to apply their knowledge of the physiology of pain to understanding how the theory worked in practice. Mary explained with the aid of a diagram how the body manufactured its own opiates in response to pain. She encouraged the students to think about how they could use the theory with patients they had nursed to look at different ways to relieve pain. A student then animatedly interjected, 'I mean that would make such sense, I didn't actually realise all that before. I can't understand why we don't do more like massage'. Mary nodded and encouragingly said 'uhuh'. The student continued, 'I always knew that there was scope for

alternatives but I just think now why, why are we not doing more, why are we not touching our patients more? It's just - what are we doing? What are we not doing? What have we been doing?' Mary agreed and said 'It's amazing isn't it, you know it's just straightforward clinical things such like touching your patient. It doesn't have to be where the pain is necessarily, just the fact that you're touching them will send, will stimulate those fibres, will probably increase the secretion of serotonin and therefore will make them feel better anyway, even if it does not relieve the pain entirely. So that's the basis of why people feel better when they are stroked or massaged. So, yes, quite right, we probably don't make use of all the alternative ways of relieving pain we could'.

The session continued with Mary leading a discussion on how different drugs and mechanisms of pain control worked. She looked at a pain ladder and at the rationale for giving drugs regularly, for example paracetamol, in order to maintain effective pain relief.

She then asked the students to do an exercise to look at how pain affected the physiology of different body systems and thus to relate the theory to practice. The students worked together for ten minutes and then fed back to the whole group. Mary stressed the basic firm agreement from all the students that it is poor practice to leave patients in pain. She also emphasised the point that patients would have a slower post-operative recovery time if they were in pain and that this would have an economic impact on the NHS. She also reinforced the notion of treating patients as individuals and not judging those negatively who appeared unable to tolerate what might be seen by the nurse as only moderate levels of pain. Mary and the students discussed the use of pain rating scales and she described their use in the area where she currently worked. Finally, she asked whether they had any questions. Several students stated that they had found the session useful and thought provoking, they thought that it had been very relevant to their actual practice.

**Summary**

Mary was a LP in surgical nursing who was committed to the development of practitioners through both education and practice. She had clear ideas about the nature of nursing and felt that practitioners should care for people and co-ordinate the services that patients required. She also emphasised that it was vital that nurses developed excellent communication skills so that they could assess and develop strategies to meet patients' needs.

As a LP Mary affirmed that her role was to provide students with the principles of specific

aspects of care and to illustrate the principles with exemplars from practice. She also felt that her role was to enable students to identify their ongoing learning needs in order to continue to develop as practitioners throughout their professional lives. Her teaching style was interactive and combined exposition of theoretical information with question and answer strategies. She was flexible and had an excellent rapport with students, changing the focus of sessions if necessary in order to meet their needs.

**AMY**

## Introduction

Amy is in her mid forties and a midwifery LP who works as a midwife for two days a week and as a lecturer in a University College for the remaining three days a week. She has recently completed the Post Graduate Certificate in Education (PGCE) and is now studying for a Master of Science degree in Health Education.

## Biographical details

Amy was born in Colombo in Sri Lanka where her parents, who were working in South India had stopped en route from England. She was sent away to boarding school in India at the tender age of five. She said that she remembered feeling that 'it was quite a long way from them, it felt like an eternity'. She was eleven when the family returned to England, where her father took up a post as a vicar. She left school at eighteen with what she described as two rather indifferent A levels. At first she was unsure of what her career path would be; however, after some deliberation she decided to follow her mother and sister to train as a nurse. She found the theoretical side of her training interesting and enjoyable but easy, particularly the physiology, since she had done Biology at school. However she found putting the theory into practice more problematic. Her first experience of nursing patients was on a female elderly care unit and the shock of what she experienced in terms of the reality of the aging process was profound:

> 'I was absolutely aghast that a human being got into that state at some point in their life I hadn't got even gone past thinking about people getting to be elderly and frail and incapacitated. It was a huge shock at the age of nineteen, absolutely soul distressing. I think even though I had seen an awful lot of trauma and human suffering in India, to see white people in that state was quite a shock'.

It was clear that Amy's first exposure to suffering and infirmity was a watershed moment for her; she was confronted with the reality of what was required to be a nurse. However, she was convinced that it was 'right' and that she could cope with it and succeed in the profession.

As her training progressed Amy also had to face the fact that she questioned things too much for her own good, and that some of the superiors she worked with did not approve of this:

> 'I found that I questioned too much when I was training as a nurse and I didn't realize that, until I was assessed, that the Sister in fact didn't like that and put me down, strongly put me down, for questioning everything and I should just get on and do as I was told... and

that was a huge shock because I hadn't had any pre-warnings that that was coming'.

It was possible that Amy's air of independence could have been interpreted as overconfidence, was seen as something to be crushed or knocked out of her by those in authority over her.

Amy met her husband a week after she took her finals and they got married within a year. At that time they were both working shifts, her husband as a bus driver and Amy as a nurse; in order to have any chance of a stable married life Amy thought that she should try to get a job with regular hours, so she successfully applied for a position as a clinic nurse. After a few months a post as a school nurse became vacant and she again successfully applied for this. She worked for two years as a school nurse in the South of England where she and her husband had moved. She also successfully studied for the school nurse qualification. She then had a career break to have her two sons. When she felt the time was right she started to work part time in a nursing home at the weekends when her husband was available to look after the children. However, shortly after she started back at work her husband was made redundant and she was forced to increase her hours in order to support the family. Her husband then decided to follow her to train as a nurse and at around about the same time Amy secured a post as a school nurse. Through her husband's contact with nursing education Amy learned about recent developments and she recognised that if she were to progress with her career she should upgrade her academic qualifications at least to diploma level. She learned that the University College ran a diploma in midwifery and, as the possibility of training as a midwife had always been something that interested her, she resolved to apply to undertake the midwifery diploma at the earliest opportunity. Amy felt that being in higher education and doing the midwifery course was 'like arriving home in a sort of way'. It was intellectually stimulating and 'it was a relief to actually be able to question and to be given answers, rather than being told "you don't need to know that"'. She felt stretched academically and thoroughly enjoyed the stimulus of study. She also felt that the practice of midwifery enabled her to develop professionally and she was able to use all her previous experience in developing her clinical midwifery skills:

'I took to midwifery... it was excellent and it's a very good mixture of health nursing and nursing ill women... I really enjoyed being a midwife, it was hugely demanding, very stressful and having two people's lives in your hands etc. but it was, I think, an aspect of my professional career as such in which I had autonomy and I could question and I could decide and make decisions and challenge doctors, so that I was moving into the autonomy that I had probably wanted when I was a student nurse'.

She and her husband had always wanted to have the experience of working in a different country so shortly after qualifying they moved to Australia. In Australia Amy continued to work as a midwife in a range of health care settings developing her skills and expertise.

After two years they returned home and Amy obtained a post as a midwife and combined working with studying for a degree in midwifery. As her career progressed Amy found the teaching aspects of her role particularly stimulating and rewarding. So, when the post at the University College was advertised for a LP in midwifery she felt that it was a logical move for her to apply for it and her application was successful.

**Amy's conception of Midwifery**

Amy believed that it was essential for a midwife to be interested in people and from that to develop an understanding of people, claiming that:

> 'I think being interested in people, for me is an essential aspect of wanting to be a midwife, wanting to be a nurse'.

She was also clear that it was essential to be knowledgeable about the midwife's role and to have excellent communication skills. She felt that as a midwife, and to some extent as a school nurse, she was able to exercise autonomy in her decision making which she had not been able to do as a staff nurse in the same way. As a midwife she was firmly committed to providing care that was person and family centered. Central to that she contended that the midwife should support women and their families throughout the process of pregnancy, labour and for the first few weeks of the new baby's life. She felt that the mother and her family should be able to rely on the midwife as being someone with whom they felt safe. This meant that the midwife must be technically competent, confident in her role and also be able to identify when she required further information or specialist expertise in order to provide safe care:

> 'In a situation that's often incredibly frightening and unknown and to make them, the mothers, the families, feel safe so they can actually be fulfilled having a child whatever that might mean for them'.

She also felt that the midwife should be someone who was honest with patients and who kept her word to mothers. In a professional sense the midwife should be someone who would act ethically and who could be relied upon by mothers and their families. As she postulated, 'if you don't know something, find out ... and keeping promises, if you say you're going to do something, do it'.

Finally, she identified that it was essential for practicing midwives to keep up to date with

modern techniques and developments. She commented that this could often be time consuming but that, because of social and technological changes and the dynamic nature of modern midwifery, being informed of current research and developments was essential in order to be able to provide the best possible care. Amy had developed these concepts about midwifery from her own considerable experience of working as a midwife with other health and medical professionals in a variety of settings in England and Australia.

**Amy's principles of practice as a lecturer practitioner**

From Amy's experience as a LP as well as from having completed the Post Graduate Certificate in Education (PGCE) she had developed ideas about her practice as a LP. They can be summarized as follows:

- to provide students with the knowledge necessary for competent midwifery practice, notably physiology and the theory and practice of effective communication with people
- to enable students to understand the theoretical concepts underpinning practice and therefore to apply theory appropriately to practice
- to enable students to develop as questioning critical thinkers, and reflective practitioners, able to influence and change practice
- to direct students to relevant practice related information sources
- as a practicing midwife, to be a role model for students

Amy was concerned to provide students with knowledge that they required for competent safe practice. She identified that a key area was knowledge of physiology, particularly of the normal reproductive system and the physiological processes involved in pregnancy and childbirth. Amy thought that students required not only to have the knowledge necessary for practice on the day that they qualified as midwives but also to be able to continually update and refine that knowledge as necessary throughout a lifetime of practice. They would then be in a position to critically evaluate the evidence upon which their practice was based. Amy was keen to emphasize the links between theory and practice and her very strong view was that her current role as a practicing midwife, albeit part time, enabled her to demonstrate these links by using exemplars from her everyday practice to illuminate her classroom teaching.

Amy actively encouraged students to challenge and question her in class and in turn she challenged them to produce evidence to support their ideas and perceptions.

In her classroom management Amy was a role model, demonstrating how she expected students to conduct themselves in practice. She was clear that her role was to enable students to develop as questioning critical thinkers, able to change and influence practice. Through her own assertive questioning stance she empowered students to be able to question and challenge practice. The classroom provided a safe environment where students could rehearse arguments and explore ways in which to challenge assumptions about clinical care.

Vitally Amy felt that her work as a clinical midwife authorized her to demonstrate her familiarity with the real world of current practice in her classroom based teaching.

**From principles to practice**

Two of Amy's teaching sessions were observed. They were tape recorded and detailed ethnographic field notes were made. Both sessions were with the same group of students and took place in a well equipped lecture room, which provided all the facilities necessary for teaching midwifery students.

**First session: Perineal suturing**

This was taught to a group of eighteen midwifery students who had completed eight months of their eighteen month degree programme. All of them were qualified nurses and some had extensive experience as nurses in a number of specialist areas. The aim of the session was to provide knowledge of the relevant physiology and simulated practice of perineal suturing. Amy combined a formal teaching strategy with demonstration; extracts from a video and a very informal interactive practical activity designed to enable students to practice suturing. At the outset of the lesson Amy indicated that it would be interactive and that she would expect all students to practice using suturing material.

She started the session by asking the students about their experience, either personally or professionally, about suturing or having been sutured. She asked whether anyone had sutured wounds when working in an Accident and Emergency Unit and a brief discussion ensued about how this might be different from suturing patients in midwifery.

Students who were also mothers contributed to the discussion and there was agreement about the need to respect privacy and for the process of suturing to be undertaken with skill and sensitivity. She emphasized the necessity for obtaining consent from women for suturing as would be required for any invasive procedure. She raised the issue of pain

relief for the procedure and cited recent evidence that women experienced severe emotional and psychological trauma as a result of inadequate pain relief. The students were then shown a short video of the important issues in suturing including detailed anatomy of the perineal area following delivery and of the importance of correct suturing technique to enable the perineum to heal as quickly as possible. This was supported by evidence on the video from research that had been done on perineal healing. The students were obviously interested in the video, and listened attentively and discussed issues in groups when it was finished. Amy then reinforced the main points from the video, for example the importance of locating the apex of the episiotomy or tear, the need to keep the suturing field sterile and the difficulties of this when, for instance, opening a pack of suture material.

She reminded students about the relevant physiology and she drew their attention to the connection between a knowledge of the physiology and how suturing should be undertaken.

Amy then divided the group and half worked with her and half with her colleague. She gave students materials for practicing suturing and she demonstrated key points, for example how to hold a needle holder, how to remove the thread on the needle holder from the sterile pack without it becoming contaminated. All students then practiced, with Amy or her colleague checking and advising each student. The lesson continued with Amy demonstrating different aspects of suturing, the students then practicing and the lecturers advising and assisting as necessary. All the students were fully engaged in the activity; all practiced and were able to discuss their technique with Amy or her colleague. Amy then replayed part of the video and students were able to compare their techniques with the video. They then were able to ask questions about technique and specific issues; for example a student said 'but I am left handed'. Amy answered 'If you are left handed use your left hand to hold the needle holder and adapt as you would when doing a delivery'. She commented that 'left handed people, I think from discussing it with colleagues, you have to take the needle out of the packet and reposition it for a left handed person around the other way'.

Amy then demonstrated actual suturing on a model and she talked through what she was doing. She made frequent reference to what she did in practice; for example, as she had small hands she showed them her own technique for holding the needle on the shaft of the holder, which was rather different from how they might have seen other people holding

it with a scissor hold. They discussed the differences between vaginal wall, muscle tissue and skin. The students then continued to work on their own models while Amy made positive comments such as, 'Yes, lovely, well done' as she saw what they had done with the suture materials. She corrected some students and she reinforced the practice of what they were doing with the needle and suture material; 'don't forget we have got a semi-circular needle, so use the shape of the needle to go in and come out'.

Amy's frequent references to her own practice underlined her principle of being a role model for students as a practicing midwife. She commented on the realities of practice and the difficulties; for instance, how the suturing of a tear differed from suturing an episiotomy.

After all the students had practiced suturing Amy drew the session to a close. She reminded them about practice materials that were available for them to use in the clinical areas and that the video that they had seen was in the library for them to borrow.

**Second Session: Male and female reproductive systems**

This session was to the same group of student midwives in the same well equipped teaching room. The session lasted one hour and it proceeded at a brisk pace with students being fully involved in the learning process.

Amy introduced the session and discussed the need for midwives to have a detailed comprehensive knowledge of both male and female reproductive systems. She stated that she had made the assumption that they would already have detailed knowledge of the male and female reproductive systems from their previous studies, so that the current session should just be revision. She gave the students a very detailed incomplete handout of the male and female reproductive systems and she suggested that they worked together in pairs for ten minutes to complete it. The students worked together and there was a buzz of discussion in the groups as they completed the handouts. Before providing the answers Amy asked the students whether they had felt that this exercise had been worthwhile and easier or harder than they thought it would be. One student commented 'it was much harder than I had thought it would be', and one said that 'it was worrying that I did not know it all'. Several students appeared to be discomfited by their own lack of knowledge of the subject and there was some embarrassed laughter about the fact that they were nearly half way through their midwifery degree without being able to demonstrate that they had a comprehensive knowledge of the basic anatomy involved

in human reproduction. It was clearly an effective strategy to enable students to assess their own learning needs and it was one which the students found very worthwhile.

Amy then provided the answers to the handout on the overhead projector. She first provided a detailed explanation of each part of the female and then the male reproductive systems. There was discussion of the anatomical similarities between the female clitoris and the male penis. There was also discussion linking the anatomy of the fourchette with the session on suturing they had undertaken the previous week. Issues from practice such as subfertility and undescended testes were commented on. She asked students 'what is one of the tests a paediatrician will do when examining the genitalia of newborn baby boys?' A student responded 'they will check to see if the testes have descended'. Amy said 'yes and if they have not descended what happens usually with a newborn baby?' The student said 'they will wait a while especially if the baby is pre-term but if they do not descend then they will have to be operated on'. Amy then challenged them to explain the action of the 'morning after' pill and also to identify why prostaglandin found in semen might mean that intercourse triggered labour to start. There was a lively discussion about the links between the anatomy and physiology of the female reproductive system, conception, pregnancy and labour.

At the end of the session Amy told the students where they could find further information about the subject by providing a reference list for them. She urged them to ensure that they made up gaps in their knowledge that they had identified as a result of the session.

**Summary**

When Amy started nursing she was shocked by suffering but she knew that she could cope with it. She worked for several years as a nurse in a range of health care settings, combining work with being a wife and a mother. She then trained as a midwife, an area of practice she found hugely demanding but enormously rewarding. After she qualified the family lived and worked in Australia for two years and she was able to develop her skills in a different environment.

Amy thought that her role in midwifery education was to work with students as a facilitator of their learning. As a role model she challenged them to provide sound arguments for any proposed course of action and she expected them to challenge her if necessary. She worked systematically and devised strategies for enabling students to identify their learning needs and deficiencies and to develop ways to meet these needs. She constantly

strove to link theory with practice by giving exemplars from her own practice and she prompted students to reflect on their experience in relation to the theory underpinning practice.

## BEN

### Introduction

Ben in his mid thirties is a LP in Mental Health nursing. He works for three days a week as a lecturer in a University College and for the remaining two days he works on various clinical practice projects in an NHS trust. He completed a teaching qualification several years ago and he is currently studying for an MSc in Mental Health Nursing.

### Biography

Ben was born in Derbyshire and lived there all his life until he moved to the south of England three years ago. He described his childhood as average. He had a younger brother and his mother took time out from work as a teacher while they were both very young. He enjoyed school and always did well; he was more of an academic student than his brother, who was a sportsman. He studied Biology at university and graduated with an upper second class honours degree. During the vacations he worked as a health care assistant in a mental health unit which specialized in the care of older people. He remembered that he found his first exposure to caring for elderly confused people very traumatic, stating 'that very first day I was very close to walking out'. However, with the support of the other staff he gradually got to know the patients as people and to understand their characters and he began to enjoy the work. When he graduated he did not have any idea about career paths and he continued to work as a health care assistant. The nurse manager suggested that he should give nurse training a try, so eventually he thought that 'it would be something that would keep my brain active while I actually sort out what I am going to do'. As Ben already had substantial experience in mental health care, that branch of nursing was the obvious choice.

Ben stated that his training was poor; it certainly did not stretch him academically and he was always at the top of his group. He wrote many of the assessments from a 'common sense point of view' and he was disappointed that more was not expected of him. As a science graduate he was astounded to find that there was very little physiology in the course: 'it was striking that I was doing a nursing course and yet there was no physiology. You could probably, in three years, squeeze the physiology into half a day'. He thought that he learned about practical skills when he was on placements but he was taught very little about the theoretical background to support practice. Nevertheless he felt that he did develop personally during his training even though there was nothing within the

curriculum, which facilitated this development.

After he qualified he worked as a staff nurse but he already had clear ideas about his long term career aspirations:

> 'I didn't see being a clinical nurse, working on a ward or wherever, as being a long term option for me... I decided that I would have to take a particular route and I made that decision right at that very beginning and that route was always going to be education'.

He therefore applied to do a Certificate in Education as soon as he could. He continued working as a staff nurse and was promoted several times; at one point he managed the ward for six months. More than ever he felt that education was the direction into which his career should ultimately develop and he was successful in his first application for his current post.

**Ben's conception of nursing**

Ben believed that the essence of mental health nursing 'is really about your ability to be able to communicate with people and to have empathy with people and to be there in a genuine capacity'. He explained that he felt that people who came into hospital were facing a strange environment, they needed to feel that there was 'someone to actually interact with them in a way that shows that you have caring within you'. He developed this approach to mental health nursing from experience and from observing other practitioners. Sadly, he declared that he had learned more from seeing bad practice, as he had seen some nurses who had become immune to patients' distress and feelings about their illnesses. He had also seen nurses who had used their position to exert power and control over patients, obviously more concerned about their own self gratification than their patients' needs. He affirmed that care was not just concerned with the physical but there was always an emotional element to it. He acknowledged that as a nurse you should be able to feel some of the pain and distress that the patient was feeling and be able to empathize with it without being overwhelmed by it: 'I think that some people can nurse and have a barrier there'. He was convinced that patients have a feeling 'for where you are coming from as a person'. He felt that he had been able to make a genuine relationship with patients, as he acknowledged: 'I always felt that I was generally quite well respected by the patients themselves, which was important to me'. He also identified what for him were the 'more tangible professional parts of the role' in that he was a very well organized person and he deliberately created a particular atmosphere on the ward when he was in charge. He attributed this approach partly to his own personality ('I'm

quite laid back generally') and partly to his understanding of specific ways of dealing with people who are distressed or disturbed:

> 'I would never contribute to escalating tension on a ward which a lot of nurses did. Because of their approach and their antagonism and antagonistic way of dealing with people, I always felt escalated tension, and I was trying to de-escalate it, and I think I achieved that and I know that feedback from people that I worked with is that they liked to work with me because the environment, the feeling on the ward, was different in a positive way to what it was when they worked with other people'.

He was convinced that each individual nurse had an influence on the climate or atmosphere of the ward and that they could influence it positively or negatively according to how they related to other members of staff and patients. It was clear that Ben also felt that nurses should have excellent communication skills in order to provide the best care for patients.

**Ben's principles of practice as a lecturer practitioner**

Ben had developed principles for practice as a LP from his experience as a part time lecturer, as well as working as a LP and from having completed a PGCE. They are summarized as follows:

- to improve students' understanding of how theoretical concepts (mainly science based) related to the practice of mental health nursing
- to enable students to work with that knowledge, to develop and change practice
- to enable students to understand the nature and pharmacological action of the medications they would be administering to patients.
- to enable students to understand the nature of specific illnesses.

Reflecting upon the almost non-existent science content in his own nurse training, Ben affirmed that having a thorough understanding of science, and specifically biological science, was vital for nurses to be able to provide the care necessary for patients in the twenty-first century. He had a particular interest in pharmacology and in understanding how drugs worked on the brain. He felt that it was vital that nurses who were administering drugs had a clear understanding of how they worked and of how they might interact with other substances in the body.

Ben had a very professional, interactive style of teaching: in his sessions he expected students to question him and he questioned them. He frequently asked them to think about what they had seen in practice and to identify how it related to the theory he had

presented to them.

**From principles to practice**

Two teaching sessions were observed; they were tape recorded and detailed ethnographic field notes were made. Both sessions were with the same group of students. Ben had built up a good relationship with them as he had been teaching them on this part of their programme for the last four months. The sessions were taught in annexes of the main part of the institution. The first session was in a well equipped informally laid out teaching room; the second session was in a rather small room which was not well equipped and which was badly affected by traffic noise from a busy road.

**First session: Inorganic disease: Management and treatment of depression**

Ben introduced the session by reviewing what had been covered last time they met, which was a few weeks ago as the students had been undertaking clinical placements away from the University College. He commented that they would be able to reflect on what they had seen in practice in relation to the physiology of diseases that they would be looking at. He asked them to think about specific clients/patients that they had looked after and to ask questions as the session progressed. He confirmed that the session would focus on the underlying physiology of depression and to examine how and whether current practice was based on evidence. An example of the question and answer strategy employed by Ben was as follows: Ben asked the group 'What are the main features of depression? Is depression an illness?' A student responded by saying 'It can be.' Ben asked 'What is depression about?'. Another student responded by saying 'There is reactive depression; something happens and the patient reacts to it by becoming depressed'. Ben agreed and said 'some patients are subjected to experiences, for example bereavement, which causes them to become depressed'. Ben then asked 'How do we treat depression - in terms of neurobiology?' Several students answered 'Antidepressants'. They continued to discuss treatment methods and then Ben moved the session on to discuss mood and the difference between 'Monday morning blues' and depression. They then discussed suicide and self-harm as serious consequences of depression. Ben emphatically stated 'don't ever let your guard down', and cited evidence which suggested that a patient who was depressed and who expressed suicidal thoughts may well commit suicide at some point. He linked the issue of depression with the Government's Health of the Nation targets, one of which is to significantly reduce the

numbers of deaths from suicide over the next few years.

From recent studies Ben outlined the arguments concerning predisposing factors to depression and reviewed the nature/nurture debate. He confirmed that physiological changes could be identified in the brain of patients with depression, no matter what had caused it.

Ben then moved the session on, changing his teaching strategy by showing slides which examined the biological genetic basis of mental illnesses. The first few slides showed a continuum of genetic loading of diseases, schizophrenia having a high genetic loading, Post Traumatic Stress Disorder (PTSD) having a low loading, and depression having a mid genetic loading. The students took notes from the slides about symptoms of depression, for example loss of sleep, loss of libido, either weight loss or weight gain, patterns of thinking, for example pessimism, suicidal or homicidal thoughts or impulses and self neglect or self harm. One student asked about optimistic and pessimistic personalities: 'Is this when we talk of the glass half empty or the glass half full?' Ben agreed that there were people whose personality predisposed them to being pessimistic or optimistic and that this could be related to whether they were likely to become depressed. Continuing with the slides Ben expanded upon the illustrated risk factors in relation to age and gender for depression, with women at higher risk between 20-40 years of age and men at greatest risk over 65 years of age. He affirmed the evidence shown on the slides that married women have a higher risk of having depression than those who are single and that the evidence is the reverse for men; however, women following pregnancy had the highest risk of all. They discussed the validity of treatments for depression and he showed a slide which underlined the cyclical nature of depression, which may continue for years or even for life. Ben then showed a slide demonstrating the strong evidence from trials that it is better to treat depression for the long term outcome for patients than not to treat. Ben confirmed that drugs such as Prozac have been used very widely and that they were powerful substances which altered the brain chemistry, and they should be used with great caution. He stated that in order to reduce the possibility of any side effects they should be withdrawn very gradually. In relation to the use of Electro Convulsive Therapy (ECT) for the treatment of depression he affirmed that its mode of action was unknown. He commented that 'drug companies have done research, so it must be viewed cautiously, but it does seem that keeping people well on ECT alone is less likely than in combination with medication'. Ben continued to show slides of the mechanism of the action of antidepressant drugs, showing the physiological changes which the drugs

brought about. He encouraged students to comment on what they had seen in practice in relation to the treatment of depression. The session moved on to explore drugs commonly used in the treatment of depression, older and newer drugs, and their side effects. For example patients taking Monoaimine oxidase inhibitors (MAOI) must be aware of untoward and serious side effects if they ate certain foods. As an illustration of what that might mean in practice Ben noted that 'patients on MAOIs must not eat cheese sandwiches!' Ben declared that it was vital for nurses to be aware of possible drug interactions and side effects such as drowsiness, constipation or unsteadiness. It was particularly important to have this knowledge when looking after older people who may be frail and/or confused. He acknowledged that the newer drugs worked more selectively and were know as 'cleaner' as they had fewer side effects.

Ben concluded the session by asking if there were any questions and asked the students whether they had found it helpful and enabled them to understand some of the issues in the treatment of depression. The students responded very positively one stated 'it has been helpful'. They left the room with some of them still talking about issues covered in the session.

**Second session: Organic illness: Alzheimer's disease and dementia**

Ben introduced the session outlining what he intended to cover. He asked students 'What do you understand organic illness to be? Two students replied 'irreversible condition', 'dementia'. Ben agreed and acknowledged that it was important to differentiate between an irreversible condition which would continue to deteriorate and a drug induced psychotic illness which might improve as the effects of the drug wore off. In the current session he would concentrate on exploring the physiological changes that occur in the brain with organic illness (dementia) which are permanent and progressive. He stated that it was important to identify what occurred in the normal aging process and how dementia differed from this.

He then asked them to work in groups for five minutes to consider the differences between normal aging and dementia. They fed back the main points and Ben summarized them on the flip chart. There was then a lively discussion about why this should be issues such as genetics or injury or lifestyle factors were discussed with nature versus nurture being vigorously debated.

Ben then provided information about the incidence of dementia; he stated that in those

over 80 the incidence is 20-25 % and he affirmed that the older a person becomes the more likely they are to become demented. Approximately 800,000 people in the United Kingdom have the disease. He explained that dementia affected the cerebral cortex of the brain. Using the whiteboard as a visual aid he explained the physiological changes that occurred in the brain in patients with dementia. He stated that there was a build up of plaques and tangles in the brain tissue causing its permanent destruction. A provisional working diagnosis would usually be made based on clinical symptoms the patient displayed, but it could only ever be confirmed at post mortem. Ben illustrated by drawing on the whiteboard the way in which beta-amyloid proteins in the cerebral cortex wrap around to form plaques and yellow bodies, which shrivel around plaques and lead to cell death. Excess TAU proteins cause tangles, which also lead to cell death. He affirmed that the latest research into treatment was exploring the possibilities of reducing beta amyloid proteins in the brain. Ben explained that a drug called 'Aricept' was being used to treat dementia; its action was to inhibit the breakdown of acetylcholine, which was known to be linked with memory, so the symptoms of memory loss were treated, but not the underlying cause. Ben and the students discussed the ethical dilemmas and issues involved in using the drug. For example, Ben asked 'When do you stop using it? How is that decision made and who should make the decision?' He asked 'can you put a price on quality of life?' He and the students discussed whether the drug raised false hopes in patients or their families and what the role of the nurse could or should be in all of this. As the drug only masked the progress of the disease, when it was withdrawn there was often a rapid deterioration of the condition.

Ben then moved the session from the examination of physiological issues to consider the reality of dementia for patients, for their families and for nurses. It was agreed that there were some similarities in caring for patients with dementia to patients who were being treated palliatively for a terminal illness. In each situation it was the quality of life that the patients had that was of paramount importance as in neither situation would there be a cure. Most of the students had nursed patients with dementia and Ben very sensitively and with great insight explained the reality of the disease. 'For a patient with dementia they will forget who they are, who their loved ones are, communication will be disrupted, there may be the risk of injury, there will be a loss of independence, a loss of dignity, a loss of autonomy and a loss of insight and awareness.' He commented 'all these symptoms pose great challenges for nurses to provide the highest quality of care for patients'. As he explained the symptoms with illustrations on the whiteboard the students

were attentive and interested; they contributed from their own experience both personally and professionally. On the whiteboard Ben provided the technical terms for the symptoms and gave examples of how they were seen in patients. Often patients with dementia lose the skills they have for daily living. Nurses must be able to help them with these to preserve their dignity and individuality, often in difficult situations where patients may be aggressive because of frustration at not being able to communicate effectively.

Ben ended the session by saying to the students that:

> 'excellent nursing care is vital; it requires a very high level of communication skills from nurses to find out what patients' needs are and to support them. I will leave you with that thought'.

**Summary**

Ben came into mental health nursing having completed a biological science degree. He believed that nursing required practitioners to develop excellent and effective communication strategies with patients and their carers. As a practitioner he deliberately set out to create a positive atmosphere in any working situation. He felt that people who were distressed and disturbed needed to be cared for in a calm environment, which would facilitate therapeutic intervention and treatment. He firmly believed that mental health nurses should be able to combine a thorough understanding of physiological issues with nursing expertise.

Ben believed that his role as a nurse educator was to enable students to have a thorough understanding of the physiological background to different aspects of nursing care. He thought that it was crucial that students were able to understand how disease affected the person and those close to them. As a nurse educator he valued students' life and practice placement experience and used it as a vehicle for them to reflect on what was being taught in the classroom. He had an interactive teaching style, frequently using a questioning technique; he also used different pedagogical strategies to enable students to maintain their concentration and interest.

# Part Four

# Discussion and Inferences

## Discussion

## Conclusion

## Discussion

There was a combined approach to the analysis of the cases based on the work of Yin (1994), Miles & Huberman (1994) and Strauss & Corbin (1990) in a modified grounded theory approach. The analysis commenced with the collection of the data and involved a constant iterative process thereafter. Many themes and foci were identified, coalescing around the following two key areas: the Nature of Nursing, and the Nature of LP professional knowledge, each broken down into further sub themes as shown in the Figure below.

Further details of the way in which the data were analysed can be found in the methodology section in Part Two of the study.

**Figure 3**

**Table showing the themes that emerged from the data**

| **The nature of nursing** |
|---|
| • Care |
| • Communication skills |
| • Ethical practice |
| • Creation of a therapeutic environment |
| **The nature of LP professional knowledge** |
| • Role modelling |
| • Delivery of teaching |
| • Elaboration and Guidance |
| • Reflection |

## The nature of nursing

In 2003 a report by the Royal College of Nursing entitled 'Defining Nursing' considered definitions of nursing. It concluded that the conception of nursing was difficult to describe adequately and it was often poorly understood (RCN 2003). This was not a new phenomenon as even as long ago as 1859 Florence Nightingale stated 'The elements of nursing are all but unknown' (Nightingale 1859:2). The authors of the RCN (2003)

document endorsed the notion that it was a dynamic concept and they were of the opinion that nurses had their own personal conception of the nature of nursing. However, they thought that often these ideas were not put into words and therefore were not shared or discussed with others in the profession, or, more widely, with patients and lay people. Alexander (1994) also commented on the difficulty of arriving at a definition of nursing. She observed that nursing was the integration of the very simple with the highly complex and she affirmed that the holistic nature of nursing care was much more than the sum of its component parts:

> 'Good nursing is such a mixture of the very simple and of the extremely complex. Good nursing, which we can all recognize when we see it but are only recently beginning to articulate, is a totality, a whole, which is very much more than the sum of the parts.'
>
> Alexander (1994:81)

Hockey (1979) described nursing as being a unique combination of the application of the art of nursing with nursing science. This implied that it required an amalgamation of knowledge gained from science with the ability to relate to people and to assess and develop strategies to meet their needs for caring interventions.

In this study each of the subjects articulated their personal conception of nursing and all agreed that it was a heterogeneous notion, which they found problematic to define adequately. Notwithstanding the complexity of the issues involved, they all identified certain characteristics as being crucial components of nursing with several further ideas being articulated by one or more of the subjects. The key characteristics were: care, skilled communication, ethical practice, and creation of a therapeutic environment.

**Care**

Interestingly, the RCN (2003) document did not explicitly identify care as an aspect of nursing even though the notion of care was implicit throughout it. All the subjects in the study were clear that nursing involved physical and emotional aspects of care. The view of Watson (1988) that:

> 'nursing within science as well as within society is a demand for cherishing the wholeness of the human personality'
>
> Watson (1988:29)

was highly relevant to the ideas expressed by all of them. Clearly, the physical and emotional elements of care were not only complementary but overlapping. In exploring the notion of care with the LPs the totality of the concept was examined and endorsed by

all of them. Their ideas were congruent with those that Benner (1984) articulated when she avowed that the concept of care required an amalgamation of two aspects, the emotional and the physical. She stated:

> 'We do violence to caring when we separate in our practice the distinctions we are able to make conceptually between the 'instrumental' role and the 'expressive' role. The expert nurse melds these two roles.'
>
> Benner (1984:170)

Even though they did not use the precise terminology it was clear that all the subjects agreed that care required nurses to have excellent technical knowledge (know that) upon which the process knowledge required for (know how) practice and skill was formulated (Ryle 1949).

The notion of care is not the unique province of nursing and in teaching the concept of care was explored by Noddings (1984) and Ben-Peretz (1996) who stressed the need for reciprocity in care. Noddings commented that the caring relationship involved a dependence between the parties. She further commented that the attitude of the one caring for an individual is the most influential and important part of the experience for the person being cared for. This accorded with the point Ben made about the genuine relationship which should develop between nurse and patient, which he believed was a crucial aspect of the essence of nursing. Peter's comments about the fact that nursing was an activity which was absorbing and rewarding as well as being demanding resonated with the idea of caring involving a reciprocal relationship between carer and cared for. He commented that he became 'hooked' on nursing when he realized just how interesting, exciting and personally rewarding it could be to care for people, to be significant to them, at crucial times in their lives.

The knowledge required to undertake skilled nursing actions expertly requires a sound understanding of normal human physiology. For example, Jane specifically stated that nursing care required a deep knowledge and understanding of biological science in order to be able to look after sick people intelligently. She aimed to provide students with the building blocks of knowledge and information which they would need to be able to care judiciously for patients in the modern NHS. She also encouraged students to assess their own learning needs and to develop the skills to become life long learners who were able to meet future demands for health care. Amy felt that the competence necessary to provide safe physical care for pregnant women and newborn babies was based on a deep knowledge and understanding of all aspects of the physiology of pregnancy and childbirth.

In addition she felt that it was necessary for midwives to have a thorough knowledge of the legal and ethical professional issues underpinning midwifery practice.

The emotional aspects of care required different but equally significant knowledge and skills. All the subjects felt a crucial element of nursing was to develop a relationship with patients. This may require the nurse to give of her / himself to individuals in what Smith (1992), following Hochshild (1983), described as the 'Emotional Labour of Nursing'. Peter commented that he remembered as a student the first time he had seen an experienced nurse demonstrate expert care with a patient; he became aware of just how much this had cost her in terms of emotional as well as physical commitment. Further, he firmly believed that care required practitioners to protect the rights and dignity of people they were looking after, which was also a way of providing emotional support. Several of the subjects felt that care required the practitioner to connect with patients and their relatives, which could be described as having empathy with them. Ben, in particular, affirmed that nurses should be genuinely empathetic with people who were sick or distressed. The concept of empathy in nursing was cogently described by Henderson (1964) who said that nurses should:

> 'get inside the skin of each of (her/his) patients in order to know what he / she needs'.
>
> Henderson (1964:62 – 63)

Kunyk & Olsen (2001) further examined the conceptualization of empathy and they argued that 'one of our basic human needs is to be understood' (Kunyk & Olsen 2001:318). They further argued that empathy enabled nurses to truly understand their patients and thus to meet their requirements for health care. Having considered ideas from key nursing theorists they concluded that empathy was the core of all nurse-client interaction. Hem (2003) claimed that empathetic nurses needed to be aware of their patients' vulnerability and dependency, which were characteristics of human experience. She asserted that nurses therefore should be aware of their own vulnerability. She stated:

> 'Only if nurses are able to realize their own vulnerability and dependency are they able to identify with patients' feelings.'
>
> Hem (2003:104)

The concepts of care articulated by the subjects were similar to those of Davies (1995) and Street (2001) who argued that nursing required a 'new professionalism' which combined a professional approach with an acknowledgment of the need for a caring role

as it had been traditionally conceived. They contended that nurses should be engaged with, have a relationship with, those they cared for; they should work in an interdependent way, embodying the use of self as part of their therapeutic activity with patients with whom they have empathy. They should negotiate an active approach to patient care and they should reflect on experience and expertise rather than presenting the stance of possessor or master of knowledge.

In contrast to the other subjects Peter believed that care involved being concerned with wider facets of the social and political context of health policy and provision. His nursing experience had involved working with patients who had been ostracized from society because they were HIV positive. He believed that as a nurse he should be an advocate for his patients (Thomas 1999, Godsell 1999). Geoffrey (1998), who examined the concept of advocacy in the nursing of patients who were dying, concluded that some ritualistic nursing practices served to distance nurses from patients, thus inhibiting them from acting as advocates for their patients. He contended that it was only through nurses providing individualised care to patients that power structures would be challenged, so that they could act as advocates for patients. Peter had been involved with lobbying for change at a local and national level to the way in which his patients with HIV were cared for. His knowledge of politics and government from his previous studies meant that he had a thorough understanding of political processes and how to initiate and implement change at a macro and micro level. He was proud to have been part of a team which provided dignified, humane and individualized care for patients.

**Communication skills**

Excellent communication skills were thought by all respondents to be a vital component of nursing. Amy contended that it was fundamentally essential for a nurse or midwife to be interested in people in order to be able to provide apposite individualized care:

> 'I think being interested in people for me is an essential aspect of wanting to be a midwife, wanting to be a nurse; I feel you need to understand people in whatever context they're in and as such allowing them to talk to me about themselves so that I can understand them.'

For all the participants communication was identified as being a two way process; it involved receiving as well as transmitting information. The subjects articulated their understanding of the barriers that might be present within patient contact which would hinder effective two way communication. For example, patients who were distressed, in pain or anxious may not communicate this to the nurses caring for them. They may also

not receive information being given to them by members of the health care team. This was particularly significant if the information patients were given was bad news about their medical condition, or if it was couched in technical terms or medical jargon. Benner (1984) identified that one of the key nursing functions was that of teaching-coaching patients about their health status or illness. She argued that nurses were able to assess when a patient was ready to learn more about their illness, or how to live with it; this required a high level of assessment skills, crucially communication skills. Ewles and Simnett (2003) maintained that nurses could gain information about patients' true feelings or state of mind from non-verbal cues, by listening not only to what was being said but how it was said. They also claimed that nurses should be aware of body language or facial expression and what that might mean within the totality of the communication process. All the subjects commented that in order to provide appropriate nursing care and intervention a nursing assessment was required. They identified that to undertake this accurately and effectively a relationship must develop with patients; this involved listening to them, hearing what might be behind the words as well as what was actually said. Ben affirmed that the essence of mental health nursing was having the ability to communicate effectively with people. He further stated that communication should indicate a genuine capacity to empathize with the patient and that this could be done without compromising the professional relationship between patient and nurse. Jane was also of the opinion that in order to provide optimum care nurses must be willing to become involved with patients and that the development of good communication skills was necessary to do this:

> 'I liked being with people,.... it's about, you get to know the person you are looking after, you get to know a little bit about their lives; not very much, and sometimes you know, you allow them to know a little about yours.'

**Ethical practice**

The code of professional ethics published by the Nursing and Midwifery Council (NMC) (2004b) clearly outlined the standards for professional conduct, performance and ethics that a registered nurse or midwife was expected to adhere to in her/his professional life. Among its tenets it required nurses to respect the individuality of patients and the confidential nature of any information acquired as the result of his/her professional contact with a patient. It also required nurses to be trustworthy and to identify and minimize any potential risk to patients that they might be exposed to as a result of their interaction with health services.

The way in which professional ethics related to practice was explored by Freidson (1970)

in his extensive study of the medical profession. In a later work he developed his initial ideas and asserted that a key element of professional practice implied that the practitioner was morally involved in his (or her) work and would exercise discretion within it (Freidson 2001).

Within nursing the ethical features of professional practice have been examined by theorists, in particular Watson (1988), who in her theory of nursing stressed the importance of moral values within the profession. She stated that:

> 'Caring is the moral ideal of nursing whereby the end is protection enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions and consequences.'
>
> Watson (1988:29)

Peter's ideas about the moral and ethical nature of nursing firmly resonated with Watson's (1988) concepts, who was concerned to preserve the rights and human dignity of patients. He believed that as a nurse he had a responsibility to be an advocate for people who were ill, particularly those who were suffering from an illness which stigmatized them and who therefore were not able to articulate what their precise care needs were.

Jane and Amy both affirmed that patients looked to nurses to do what was right for them. Jane declared that part of being a good nurse was to practice in an ethical manner. She felt that it was vital for nurses to meet patients' needs as they expressed them or if they were not able to address the issues at the time to say why not. She thought that nurses could demonstrate respect for individuals by acknowledging the importance of having their detailed needs met while in her care. She described these needs as at times being complex, such as some particular procedure, or more commonly simple, such as fetching a telephone or emptying a catheter bag. She affirmed that for each patient it was important for him or her to be able to rely on the nurse to meet his or her needs no matter what they were.

In relation to ethical aspects of care, Ben raised the issue of power and control in nursing practice. He stated that he had seen some colleagues act unethically with vulnerable patients; they had dominated them, exerting power and control in an unscrupulous way. Street (2001) investigated power and control in medical and nursing care. She based her discussion on Foucault's (1977) ideas of the dynamic nature of power and she held that power was a 'force which circulates' and could be 'used but not held' (Street 2001:207.). She asserted that this was itself an empowering notion, which had a dynamic quality, and it was possible, therefore, that anyone could have the prospect of exercising power.

However, she acknowledged that for various reasons, for example, social status or economic circumstances, some people would have more opportunities to exercise power than others. She, with colleagues, explored the possibilities and ways of reconstructing nursing practice to promote more egalitarian relationships between health care team members and, most importantly, with patients. She concluded that these strategies had permitted them 'to journey with sick people on their own terms' Street (2001:211). Her study echoed Ben's concerns that not all nurses acted ethically in the exercise of their perceived power in the best interests of patients. Henderson (2003) also explored the power imbalance between nurses and patients. She found that the power relationship between nurses and patients amounted to nurses giving patients the information that the nurses thought that patients could understand. There was a reluctance to share decision making with patients and thus there was a clear imbalance of power between them. She urged nurses to equalize power relationships with open communication between them and patients, and thereby making partnership in care a reality. As far as his own practice was concerned Ben affirmed that he would never try to coerce patients through the use of power or control; he would always to try to treat them with respect and dignity. He stated:

> 'I think I learned more from seeing bad practice... what I've seen is far too often people who used their roles as a nurse to dominate patients and to influence power over them and to do that in a way that's more about their own self gratification rather than about the needs of the patient.'

Clearly he had learned from seeing poor care and he was convinced of the need to perform in a way that respected patients as individuals and to practice nursing in an ethical way.

**Creation of a therapeutic environment**

The document Defining Nursing (RCN 2003) stated that one of the key characteristics of nursing was a particular mode of intervention, 'helping them (people) to achieve, maintain or recover independence.' (RCN 2003:3). Further, one of the other characteristics was 'a commitment to partnership with patients, their relatives and other carers' (RCN 2003:3). McMahon (1998) claimed nurses had a vital role in enabling patients to regain or maintain health. He contended that nurses by practicing therapeutic nursing were able to promote healing in clients/patients. He stated that:

> 'Therapeutic nursing, then, is about achieving beneficial outcomes for people by applying nursing interventions to problems designated as being those of the patient rather than the property of one discipline or another.'
>
> McMahon (1998:15)

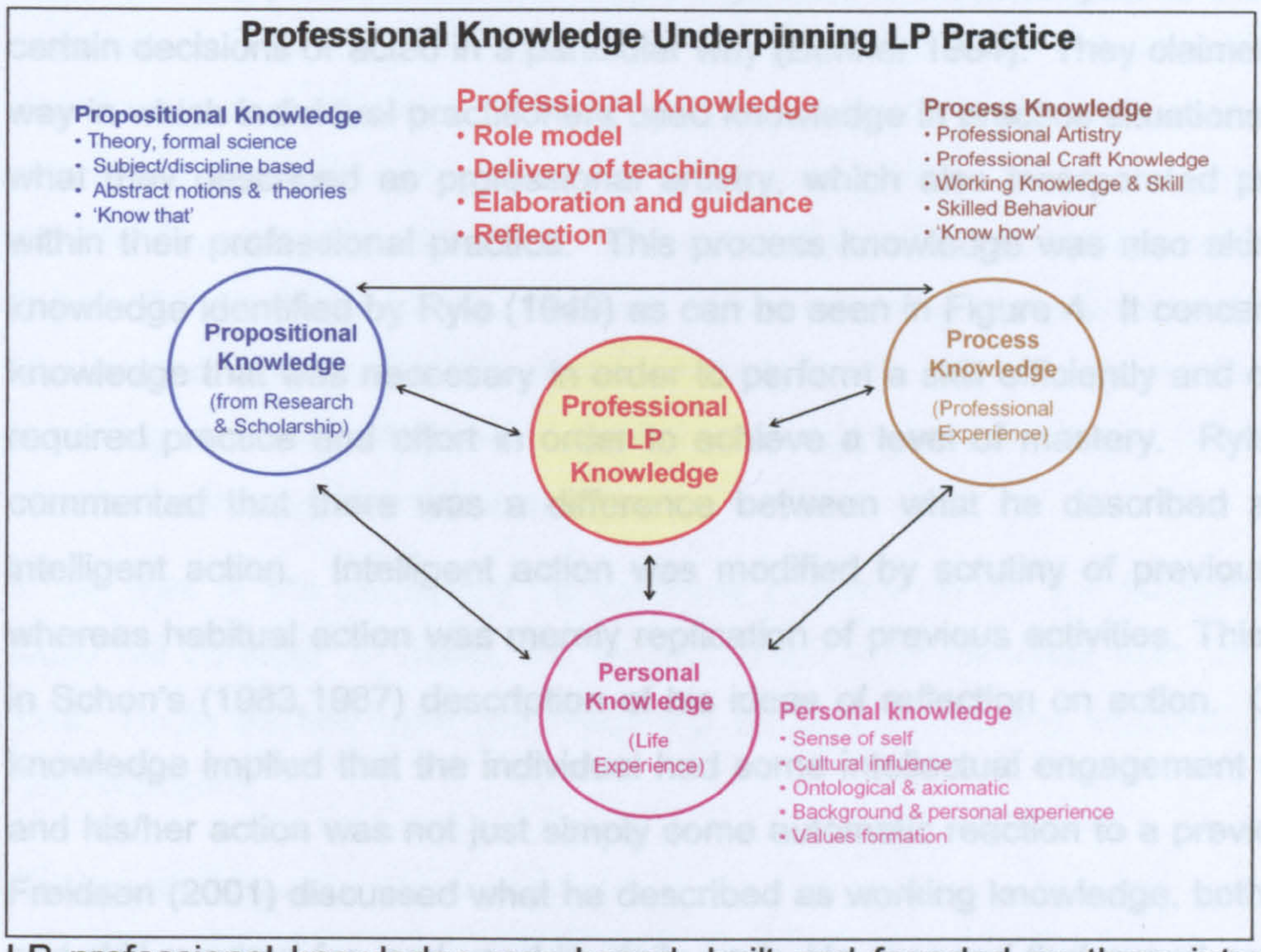
All the subjects identified that creating a therapeutic environment was an important part of their role in order that healing interventions could occur. Ben affirmed that he was well organized but also 'laid back' and he deliberately created a particular atmosphere on the ward when he was in charge. His work had been with patients who had mental health problems and he felt that it was crucial to provide a calm positive environment for them. He commented that colleagues stated that they liked to work with him because the climate or atmosphere on the ward was different in a positive way. He underlined the notion that each nurse could influence the health care environment in a positive or a negative way depending upon how they related to the patients or other members of staff. Mary provided a calm atmosphere through her own confidence and competence. Through her own confident persona she had been able to put students and patients at ease to allow nursing interventions to take place smoothly and effectively. She recounted an incident that had taken place recently when she had been working in practice:

> 'I was looking after a patient with Ann the F grade nurse... and we were talking to this patient. I wear white when I am in practice, and she said to me, well who are you? So I explained to her and she said 'oh its just that you give the impression of being the one who knows, who's in charge and has got their finger on the pulse' and I thought that's nice that is what I aim to do and Ann laughed, because she said that's typical of you Mary because that was what I was like when I was a ward manager and it just amused me because I certainly didn't have my finger on the pulse because you can't when you are there only one day a month, but it's having that air of confidence about you, I think which makes the patients have faith in you.'

Peter also described how he aimed to create a therapeutic environment when he had worked as part of a cohesive empowered health care team which had been able to provide excellent care to a group of particularly demoralised and disempowered patients. He emphasized the holistic nature of the therapeutic ward environment as it had not only created a healing milieu for patients but it was also an attractive working setting for colleagues and student nurses.

## Lecturer Practitioner professional knowledge

## Figure 4 Professional knowledge underpinning LP practice




LP professional knowledge was based, built and founded on three interlinked areas of knowledge: propositional, process and personal knowledge, as shown in Figure 4.

Propositional knowledge is the form of knowledge that was traditionally taught in universities (Higgs & Titchen, 2001). It is usually constituted from discipline based concepts which have been formulated through research. Freidson (2001) recognised that this form of formal knowledge was necessary for people who aspired to become professionals in 'specialized occupations with professional standing' (Freidson, 2001:29). However, he also commented that this form of knowledge could often not be applied directly to work settings, as it might need to be reinterpreted or modified in order to allow the practitioner to use it intelligently in whatever situation he/she found him/herself. Eraut (1994) expressed similar ideas and he stated that the interpretation of propositional knowledge was how professionals had always used it within their practice. In his seminal work Ryle (1949), argued that 'knowing that' was based on intellectual theoretical conceptions, but it was not a requirement for being able to 'know how' to perform an activity. Clearly, propositional knowledge was analogous to Ryle's (1949) 'know that' form of knowledge, and it was a form of knowledge upon which professional practice was based.

Higgs et al (2001) described process knowledge as professional craft knowledge and they were of the opinion that this form of knowledge was embedded in practice itself. It was often tacit and practitioners were not always able to articulate just how or why they took certain decisions or acted in a particular way (Benner 1984). They claimed that it was the way in which individual practitioners used knowledge in practice situations and developed what they described as professional artistry, which also incorporated practice wisdom, within their professional practice. This process knowledge was also akin to 'know how' knowledge identified by Ryle (1949) as can be seen in Figure 4. It concerned the form of knowledge that was necessary in order to perform a skill efficiently and effectively and it required practice and effort in order to achieve a level of mastery. Ryle (1949) further commented that there was a difference between what he described as habitual and intelligent action. Intelligent action was modified by scrutiny of previous performances whereas habitual action was merely replication of previous activities. This was also seen in Schon's (1983,1987) description of his ideas of reflection on action. Clearly, process knowledge implied that the individual had some intellectual engagement with the activity and his/her action was not just simply some automatic reaction to a previous experience. Freidson (2001) discussed what he described as working knowledge, both the knowledge and skill required for, and used in, daily work. He asserted that expert practitioners were able to function flexibly to change and adapt their practice as required to meet the specific demands of the work based problem or situation.

As can be seen in Figure 4, personal knowledge, on the other hand, involved everything that the practitioner brought to their practice from their previous life and professional experience. It concerned the individual's personal philosophy and moral code and would have been developed from exposure to different experiences and socialisation processes. It was also closely involved with the formation of the values which were appropriate for professional practice, values which were concerned with, and demonstrated through, the caring intimate aspects of nursing practice (Campbell 1984, Street 2001). Polanyi asserted that personal knowledge involved emotional aspects of knowledge in what an individual brought to their professional life. He described this as the 'passionate participation in the act of knowing' (Polanyi 1958:17). Carper (1978) developed these ideas further in patterns of knowing in nursing. She held that the nurse should use her /his own persona in relation to how she/he delivered care to patients. These ideas could usefully be developed in the way in which nurse teachers related to students. Higgs et al (2001) recognised that personal knowledge was an important element in knowledge that

informed professional practice and that it was developed from experience of life. It could have been developed as a result of the individual having developed a personal understanding of him/herself through reflection on life in general and on particular experiences they may have had personally or professionally. Cusick (2001) maintained that there was a dynamic relationship between professional and personal development and that professional progress could only occur when there was reciprocal personal growth. The personal aspects of the individual practitioner's world view and moral code, Cusick (2001) reasoned, was a crucial part of informing professional behaviour. Further, she posited that one of the major challenges the developing practitioner faced was balancing and integrating their personal codes with the demands of developing specialist propositional and process knowledge.

In the light of the theoretical perspectives outlined above, the following section of the study will consider, in depth, the themes which were identified from the analysis of the data. These themes were: role modelling, delivery of teaching, elaboration and guidance, and reflection.

**Role modeling**

A role model is defined in Merriam-Webster's Medical Dictionary (2002) as 'a person whose behavior in a particular role is imitated by others'. Three of the subjects in the study explicitly identified that one of their main purposes in the education of nurses was to be a role model to students. The remaining two LPs, implicitly, through the way in which they interacted with students and in the illustrations they used from practice, indicated their commitment to being a role model. The impact of being a role model was seen in a study undertaken by Wright et al (1997) who examined the influence of role models on medical students. They found that there was a direct correlation between the exposure to a positive role model in a particular medical specialty and the student's choice of first clinical position, and they recommended that:

> 'attending physicians who are excellent role models need to be identified at all institutions so that they can be encouraged to spend more time with medical students and residents'.
>
> Wright et al (1997:56)

Further, they found that a significant proportion of students felt that their personal growth and development had been influenced by their relationship with a positive role model. This was also seen in comments from Peter, Jane and Ben, who stated that they had learned a great deal about good nursing from working with clinicians who had acted as

role models and who had influenced and inspired them to provide excellent care to patients.

Within the overarching concept, different forms of role modelling from the analysis could be identified for example authenticity and authority. For example, Peter drew on his recent experience when he discussed the latest developments in the treatment of patients with HIV/AIDS. His clinical experience, combined with scientific propositional knowledge and understanding of the disease process, allowed him to speak as an authoritative role model about the reality of nursing patients with the condition. In a paper exploring how to support novice teachers, Lazarus (2000) claimed that mentors were able to act as role models for newly qualified teachers. She asserted that mentors were in a prime position to challenge the strongly held assumptions that John (1996a, 1996b) had found that teachers starting their careers held about teaching. As lecturer practitioners the subjects were in a similar situation to mentors and they were able to challenge students' assumptions and beliefs about nursing specifically and health care more generally. An example of challenging students was seen in the sessions taken by Peter and Ben in relation to their confronting students about their perceptions of people who had specific conditions such as HIV, or depression or dementia. Maddison (2004) held that being open to challenge from students was a component of being a role model. This was seen in the sessions Amy took when she encouraged students to challenge her and in turn for her to challenge them about their assumptions concerning aspects of clinical practice. Lazarus (2000) concluded that mentors acted intuitively as role models in a classroom situation and that this could be made explicit in an analytical discussion between mentor and student. Within the observations of the teaching sessions the LPs appeared intuitively to present themselves to students in particular ways to provide them with a model of professional behaviour. For example Ben and Mary had a quiet, confident, professional air when they worked with students in the classroom, this could be seen as an aspect of their own personalities but it also presented a powerful message as role models to students about what was expected of them in terms of their approach to patients and behaviour as professional practitioners.

Maddison (2004) also explored the ways in which mentors could influence student nurses to develop critical thinking skills. She held that by modeling these attributes themselves, experienced practitioners would enable students to become more reflective, analytical, clinicians. Further, she argued that good role models usually exhibited qualities which

included 'clarity, consistency and communicativeness' (Maddison 2004:84). She also felt that good role models were seen as being sincere, courteous and considerate of others. These attributes were aspects of ethical modelling and showed a way in which professional values could be presented to students. An example of ethical modelling demonstrating particular values was seen when Ben made a very compelling analysis of the reality of living with mental illness from the perspective of patients and their carers. He drew on his experience of clinical practice as he related the symptoms of illness to the pathology of the physiological changes that had taken place in the patient's brain. The way in which he spoke about his experience of caring for patients presented the role he expected the students themselves to play in their care of mentally ill people. In the light of ideas from Maddison (2004), outlined above, Ben was clearly seen to be sincere and courteous in his approach to patients and was consistent in providing the highest standards of care for individuals. He also presented practical examples of aspects of day-to-day care and management of patients, such as the monitoring of untoward drug interactions or side effects, such as drowsiness, from the medication that patients were given. He also gave a precise example of the interaction that particular drugs had with certain foods. Similarly in her session on suturing Amy constantly referred to her own practice and to how she considered not only the physiological knowledge and psychomotor skills she used when suturing patients, but also the affective aspects of knowledge that were particularly important in the intimate aspects of clinical care. She suggested that students should emulate her integrated holistic approach to the care of patients when they themselves were suturing women following childbirth. Peter was able to model his values and beliefs about nursing, which were based on personal as well as process and propositional forms of knowledge. His teaching specifically emphasized the importance of the affective aspects of care and this was demonstrated in the way in which he talked about actual patients he had nursed. His values about human dignity and respect for individual patients were clearly articulated when he discussed the issues of treating patients/people with respect and consideration. These values were also reflected in the way in which Peter treated the students, listening to them and inviting them to comment and contribute to sessions.

Bandura & Walters (1963) and Bandura (1997) identified the importance of the influence of social ties on learning. Bandura found that children were likely to model adult behaviour that they had been exposed to. He also recognized that the behaviour change was most powerful when the subjects could identify closely with the model, for example, when they

were the same age, ethnic origin or gender. Even though Bandura's (1997) studies were undertaken with children, they were of relevance when considering how the LPs interacted with students. This was seen in the LPs' interactions with post registration students who were experienced qualified nurses, often of a similar age to the LPs. Also, as Jane, Amy and Mary all taught general nurses, most of whom (92%) were women (NMC 2004a), this would be likely to add to their credibility as role models to students. The proportion of men in mental health nursing is higher that in general nursing (34%) (NMC 2004a) therefore the mental health nursing students would see Ben, a male nurse lecturer, as a credible role model.

The highly influential Russian psychologist Lev Vygotsky propounded the theory that children's intellectual development occurs under the influence of their social world and cultural background (Vygotsky (1962) (translated by Wertsch 1985)). He further argued that the initial development of speech was to allow social communication before it became internalized and became a means for the child to think. His ideas are often contrasted with those of Piaget (1952) who held that developmental processes in children occurred from within, not primarily in response to external stimuli. He emphasized the role that language had in the communication of ideas and in the social learning of children. Vygotsky's (1962) ideas could also be transposed to illuminate how adults learn in response to extrinsic factors such as social stimuli, largely in the form of verbal interaction. This could be from interaction with, and exposure to, suitable role models. Alexander (2000) also examined the relationship in teaching between discourse and action. The sessions that Jane and Ben took with students who were at the beginning of their professional lives illustrated Vygotsky's (1962) and Alexander's (2000) notions. As part of their professional learning they were required to learn specific terminology, as they would be required to understand medical language in order to carry out specific procedures with patients. Jane and Ben acted as role models in their teaching; using specific terms they unpacked precise physiological language and unfolded the meaning of the terminology to the students. For example Ben provided students with the exact expressions used to describe the complex changes seen in a patient who had dementia, terms such as; amnesia, aphasia, dysphonia and many others. This demonstrated the use of practically relevant propositional knowledge.

Bruner in his exploration of the psychology of education discussed 'the acquisition of "know how"'; he saw children as 'imitative learners' Bruner (1996:53). He argued that from a very young age children learned by imitating adult behaviours. He maintained that

in order to learn effectively, the goals of the desired learning must not only be clear but the imitator must also have the desire to achieve those goals for him or herself. Even though again this study was undertaken in relation to how children learn, the findings were of relevance to the LPs' practice. For example all the students were either professional practitioners or were aspiring to become practitioners, therefore they were highly motivated to achieve the goals of learning described and demonstrated by the LPs. Bruner (1996) further contended that this form of learning was the basis of apprenticeship learning where the novice imitated the expert and practiced a skill until he or she achieved competence. However, he cautioned against too simplistic a stance, as a combination of both explanation and commentary on the development of the skill, as well as practice, were required for mastery of a skill to be achieved. An example of this explanation and commentary on the development of skill as well as practice was seen in the session Amy took on suturing.

**Delivery of teaching**

The way in which the LPs taught students and the methods they used emerged as a significant theme in the data. Ramsden (2003) analyzed different approaches to learning; he drew on work undertaken by Roth and Anderson (1988), and emphasized that learning was 'about understanding and making sense of a few ideas, rather than a process of collecting and memorizing facts and words.' (Ramsden 2003:90). He identified key principles for effective teaching in higher education, among which were: the teacher having a desire to communicate his /her passion for the subject matter to the students, being able to communicate the subject matter clearly and effectively, and, crucially, having a relationship with and commitment to the students and to their learning. Peter's energetic darting around the classroom was an illustration of his passion and commitment to the subject and his enthusiasm to effectively communicate salient issues to students. Ramsden (2003) asserted that the principles he identified enabled students to have control over the subject matter they were learning and were likely to result in a deeper commitment from them to what was being taught. Similar ideas had previously been explored by Prosser & Trigwell (1999) who in their analysis of learning and teaching in higher education made the case for pedagogical strategies which were likely to promote deep learning in students, involving approaches which were student-centered and highly interactive. Flexibility was also a hallmark of how the LPs delivered the content of sessions and in several cases they negotiated a change of emphasis in response to

student need, which, it could be said, enabled the students to retain control over the session.

An example of an interactive strategy was demonstration, a technique that Amy used very effectively with a group of students. She based the whole of one of her sessions on firstly demonstrating the skill of suturing to the students and then providing them with the materials to practice a simulated activity of suturing; this was congruent with Bruner's (1996) ideas about the development of skills. He stated that in order to develop a skill there was a need to practice with the opportunity to discuss and constantly reappraise progress. Through this strategy students were enabled to develop as independent learners and to practice a skill in order to develop a level of competence before actually performing the skill in practice. Amy and one of her colleagues provided them with constant feedback on their progress. Benner (1984) in her exploration of the development of nursing practice, endorsed this approach to teaching students by means of demonstrating a skill. She held that guidance from an experienced practitioner was helpful for the novice to develop along the continuum towards expertise. The pedagogical strategies of demonstration, coaching, individual support and feedback were clearly seen in the session Amy and her colleague conducted as they helped students acquire the knowledge and skills necessary for the practical skill of suturing. These techniques were congruent with Eraut's (1994) ideas of feedback and coaching. He maintained that the preparation of some professional practitioners involved a form of pupilage, which enabled the student practitioner, gradually, over a period of time, to acquire the knowledge, skill and expertise required for practice. He called this the development of 'craft knowledge' (Eraut 1994:6). He also held that regular feedback on progress was essential and in some cases coaching should be provided in order to facilitate the acquisition of specific skills.

Barnett (2000) argued strongly that methods of delivery of teaching in higher education, in order to prepare students for what he described as 'supercomplexity', required strategies which challenged students to engage with different ideas and complex notions. He held that 'debates and structured workshops of all kinds should be explored so as to generate contained arguments among the students' (Barnett (2000:160). He was scathing in his condemnation of the formal lecture as a method of teaching:

> 'University teaching should see the severest attenuation of the formal lecture, if not its total abandonment. The formal lecture is a refuge for the faint-hearted, both lecturer and students. It keeps channels of communication closed, freezes hierarchy between lecturers and students and removes any responsibility on the student to respond.'

Barnett (2000:159)

In relation to the LPs' practice, the interactive methods seen in the observed sessions, such as small group work, discussion, case studies and demonstration, appeared to be highly appropriate strategies. The LPs invited contributions at the commencement of the session and used visual aids such as video clips, as well as writing on a flip chart or presenting slides on an overhead projector. They allowed students time, scope and opportunity for challenge and engagement with the lecturer and the material, as well as with their peers. Ramsden (2003) asserted that deep approaches to learning should be encouraged when teaching in higher education and that these approaches involved students being highly engaged with whatever they were learning. Within all the observed sessions the interactive strategies ensured that all the students were engaged in the session.

The participants all felt that they had developed considerably as lecturers over the time they had been in post. Their ideas and comments closely mirrored Eraut's (1994) model of teacher development which stated that at the beginning of their career teachers were concerned about themselves and their own adequacy in the classroom in terms of their ability to control the class and their knowledge of the subject. At the start of their teaching career all the participants felt that they had been concerned about issues such as class discipline and being in control of lessons at all times. They felt that they had to have vast amounts of information on hand in every lecture and several of them commented that they were over-prepared for teaching. They felt that transmitting ideas and facts to students was what was required of them, they focused on themselves and on their need to always have the answer to every question. As Jane commented:

> 'as a new teacher the feeling was that they expect me to know everything, so I tried to know everything and then I realized that that is impossible.'

and:

> 'anxiety is also something as a new teacher you kind of fret going in there and your palms are sweating.'

Their understanding of teaching had been based on the idea of knowledge as finite and static with it being passively transferred to a recipient (Hall 1996, Fox 1983). This was akin to the 'banking concept' of knowledge (Freire 1970:53). Freire (1970) claimed that some approaches to education saw students as containers to be filled by the teachers with knowledge. He argued that this attitude disempowered students and placed them in

a passive role with little or no responsibility for their own learning or even to engage with the subject matter being taught.

Eraut's (1994) model of teacher development held that as teachers moved along a continuum towards expertise they became more confident and concerned with issues such as whether students were learning what they needed to, as well as their relationship with and contribution to student learning. With confidence and experience the LPs' perspective changed; they became much more relaxed and their focus was on what the students needed to learn about the subjects underpinning practice and on how students could develop themselves as clinical nurses. Their understanding of their role developed into flexibly facilitating student learning rather than being the fount of all knowledge. Jane stated that now she would:

> 'go in with less materials and much more flexibility. If a session is not going well, because they are not understanding or it's slow and they're bored or if I am just not getting a good feeling about it... then I'll do something different, I'll switch it I'll instead of ploughing through it in the method I had in mind, as a new teacher, I would say, OK I'll just go through the session whatever and teach it the way I intended to, now, if it's not going well, I'll say, OK, you're obviously not getting this... let's do it a different way, so you know split into small groups...so I would change tack now and I think I'm more receptive to whether things are going well, so the confidence about not knowing all the answers, but flexibility to try different methods as well, I think has changed.'

Mary felt that as a consequence of gaining more confidence as a lecturer she was able to make the learning experience more enjoyable and fun for the students. She stated: 'you learn much more when you enjoy a session'. Hall (1996:180) pondered whether 'enjoyment might be a necessary stimulus to creativity'.

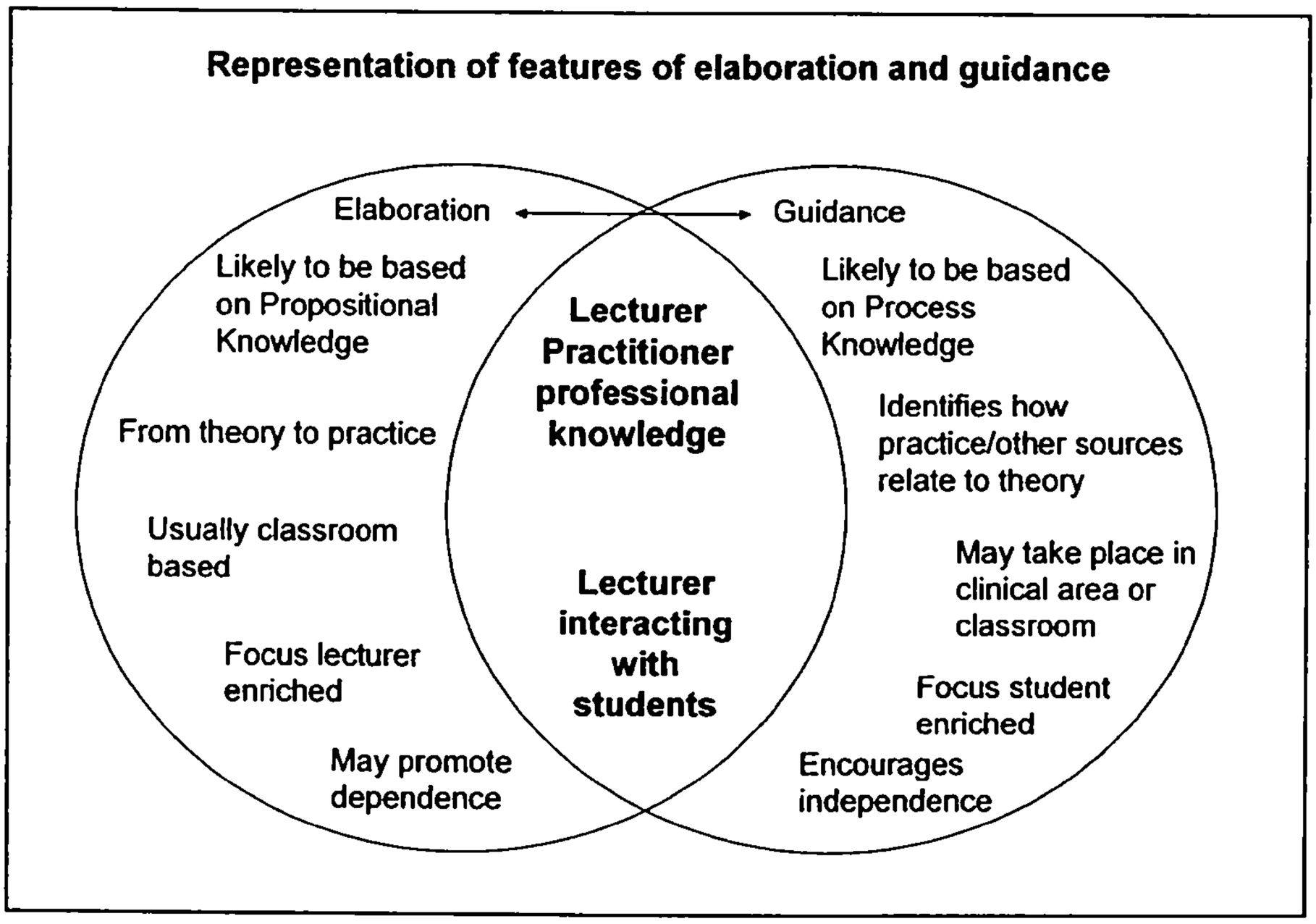
As well as identifying the development of pedagogical knowledge the knowledge demonstrated in the delivery of teaching in LP professional practice had three key elements to it: elaboration, guidance and reflection. The first two of these, elaboration and guidance, will be explored together in view of their intimate connection and then the ideas within reflection will be examined in some depth.

**Elaboration and guidance**

Elaboration and guidance as a theme from the data were two overlapping aspects of the way in which the LPs related to and interacted with students. Elaboration was seen as the way in which the LPs developed concepts for students, presented issues in detail (Ask. Oxford.com 2005) or interpreted the subject matter, usually theoretical principles, based

on propositional knowledge for the students. On the other hand inthis context guidance involved the LPs enabling students to consider issues from a different perspective, (Ask. Oxford.com 2005) and indicating how they could find different sources of information either from the practice environment or from library or internet based sources.

**Figure 5 Representation of features of elaboration and guidance**




Elaboration and guidance manifestly involved verbal interaction between students and teacher. Alexander discussed the proportion of time in any lesson, which involved someone talking and he stated that:

> 'a truth universally observable, if not universally acknowledged, that for about two-thirds of the duration of most (school) lessons somebody is talking; that about two thirds of this talking is done by the teacher; and that two thirds of the teacher's talk consists of direct instruction in the form of questions, instructions and exposition.'
>
> Alexander (2000:393)

Freire (1970) also in an analysis of teacher student relationships noted that they were characterized by their 'narrative character' (Freire1970:52) and commented on the 'involved nature of the practice of teaching' (Freire 1970:38).

All of the LPs, in elaborating the content of the observed sessions, sought to communicate aspects of different forms of knowledge to students. For example in Ben's sessions on aspects of mental illness he elaborated on, and explained to the group, the issues he

understood to be significant in the treatment of certain conditions. Primarily based on the relevant physiology, he was concerned to explain to students how specific drugs acted on the brain of affected patients. He believed that with this knowledge students would be able to deliver well-informed and excellent care to patients. Figure 5 represents how elaboration is enriched by the lecturer whereas guidance tends to have a focus which is enriched by the students and their needs and concerns. This was seen in this session with Ben in which, as it progressed, the focus changed from being on him and aspects of theoretical knowledge towards the students themselves and practice, as he guided them to consider relevant affective aspects of knowledge. He asked them to imagine what it would be like to be a confused elderly person who was unable to communicate effectively with those around them. He suggested that they visualized what it would be like to be in the place of their patients and to consider how they would react if they did not know who they were, who their carer was or even where they were. He then challenged them to think about how they would react if someone they did not know took them to the toilet and started to undress them. He declared that he would react by resisting and suggested that they might also react with some degree of hostility. Drawing on his clinical experience of working with patients with dementia he then discussed the stark reality of caring for confused people. Using process knowledge together with his professional experience he affirmed just how stressful this could be for relatives and friends.

Similarly Jane was concerned to provide students with the building blocks of propositional knowledge they would require to be able to care for patients in an intelligent way. In her elaboration of the locomotor system she provided examples that she hoped would catch the students' imagination. For example when she was discussing safe moving of patients she asked students to consider whether a giraffe or a mouse had the more stable base. She then asked them to consider what the implications of understanding the importance of having a stable base would have for them when they were moving and handling patients in practice. At the end of the session she guided students to where they could access various resources to support their learning. As can be seen in Figure 5 working from elaboration towards guidance Jane moved the focus of the session from herself towards the students and their concerns in practice. This was designed to enable them to move from being dependent on her for their sources of knowledge towards independence as learners able to search for a variety of information sources in different settings.

Peter also elaborated and expanded on affective aspects of knowledge particularly with regard to ethical issues in the care of patients with HIV and AIDS. He felt that an important

aspect of nursing patients was to act as a campaigner for them. He challenged students to recognize prejudice and discrimination against people who had certain medical conditions and guided them to consider what responsibility they had as nurses to combat injustice in the care of their patients. He confronted students with the reality of the political nature of health care and reminded them of their responsibility as professional practitioners to be advocates for their patients and if necessary to take appropriate action to address bigotry and inequity.

In the session on suturing, Amy through demonstration, drawing on process knowledge, guided students as to how they could and should develop psychomotor skills. She affirmed in her elaboration of the concepts that these skills were developed in conjunction with having a deep knowledge and understanding of the relevant propositional knowledge of physiology. Figure 5 demonstrates how these two aspects of elaboration and guidance, although distinctive, are complementary to each other. She also challenged and guided students to consider the affective area of knowledge and to imagine what it would be like to have an episiotomy or perineal tear sutured. As she elaborated on the procedural aspects of knowledge she also emphasized process aspects of knowledge and the importance of treating patients with respect and dignity at all times, particularly when they might feel at their most vulnerable. Further, Amy guided and directed students to where they could find different sources of information and resource material. These included resources provided for them in the ward environment to practice the skills that they had been introduced to in the educational context. She also directed them to where they could find written sources of information about how to further develop the skills of suturing; this included relevant recent evidence on the importance of pain relief when suturing patients, particularly following childbirth. Similarly, Jane at the end of her session on the locomotor system drew students' attention to where they could access additional resources to enable them to augment and expand upon the material she had covered in the session.

**Reflection**

Enabling students to develop as reflective practitioners was also a key theme to emerge from the analysis of the data. The concept of reflective practice can be traced back to Dewey (1933), and was further developed by Schon (1983, 1987) and Gibbs (1988). Enabling students to develop as reflective practitioners (Brookfield 1987 and Schon 1987) has become a key component of the education of nurses (Johns & Freshwater 1998, Johns 2000, Jasper 2003, Bulman & Schutz 2004, Gould & Masters 2004). In recent

years it has been taken up more widely as a pedagogical strategy in the preparation of other health professionals, for example in the education of doctors (Fins et al 2003, Ker 2003, Mamede & Schmidt 2004), and dentists (Robinson & Davies 2004). In order to enable students, the practitioners of the future, to develop the skills they would require to maintain and to continually develop their knowledge base, some authors have advocated that strategies to develop reflective practice should be embedded in all programmes designed to prepare professional practitioners. For example Van Manen (1995) posited that reflection was a fundamental feature of the life of all educators. Dahlgren et al (2004) endorsed this view and stated:

> 'We should expect university educational programmes to educate students to adopt a critical and reflective stance towards their knowledge and their activities. This means that reflection on practice can result in practice-generated knowledge.'
>
> Dahlgren et al (2004:31)

They maintained that professional practice in the twenty-first century required clinicians to critically reflect on the commonly held assumptions upon which everyday practice was based. They reasoned that this would help to provide appropriate solutions for patients' health care needs and problems; it would also have the potential to expose professional decision making to the scrutiny of patients and consumers of health care services.

Several of the LPs used specific strategies to enable students to develop as reflective practitioners. They acknowledged that many students, particularly those who were already qualified practitioners, would be familiar with the concept of reflective practice and much of what they would undertake with them would build on previous knowledge and experience. For example Mary's session on clinical supervision was entirely based on the notion of enabling students to develop as reflective practitioners through the development of clinical supervision within a particular NHS Trust. She provided students with knowledge of the theory underpinning reflection by providing a model of structured reflection for them to use in practice. She aimed to assist them to understand the potential for reflection in conjunction with clinical supervision and how it could be used to facilitate professional development for them and for colleagues in practice.

Gamble et al (2001) defined reflection as developing transformative learning in students; this was done primarily by encouraging them to scrutinize experience while it happened and then to analyze the meaning in conjunction with developing an understanding of the experience. They argued that this approach allowed professional learners to face the constantly changing demands of professional practice. Further, they claimed that it

equipped practitioners with more relevant and deeper knowledge sources upon which to base practice. Several authors identified levels of and approaches to reflection, for example Fish et al (1991), Goodman (1984), Mesirow (1981) and Johns (2000).

Bulman & Schutz (2004) adapted Goodman's (1984) theory of the focus of reflection which contended that by clearly defining the focus of reflection students would be able to develop beyond focusing on achieving given objectives, the first level of reflection, towards the second level, which was more concerned with relationships, and on to the third level, which required them to address the ethical and political context of professional practice. For example Ben, working with students on the pre-registration programme, frequently suggested that they thought about and identified issues from patients they had cared for. He encouraged students to contribute ideas to the session about the way in which they had seen care delivered to actual patients. One student asked about why Electro-convulsive therapy (ECT) was used, and he described a patient whom he had looked after following this treatment for depression. This resulted in some discussion in the session and reflection at a basic level about why the patient had been given ECT rather than antidepressant medication. At this stage in the students' professional and educational development this level of reflection was largely at the descriptive level, Fish et al (1991) or Goodman's (1984) first level of reflection. Nevertheless, in aspects of his teaching Ben was concerned to explore relationships between nurse and patient and thus would have motivated students to look beyond the descriptive at least towards Goodman's (1984) second level of reflection.

In her session on the management of pain Mary also challenged students to reflect on their experience of nursing patients who were in pain. At one point in this session when Mary had suggested that they consider non-conventional ways to help manage patients who were in pain one student had what could be described as a 'eureka' moment. Reflecting on her experience with patients and thinking about the physiology they had just been discussing, it suddenly dawned on her how she could use the new knowledge combined with her experience of nursing patients. She became highly animated as she grasped the potential of this new knowledge and to realize how her practice could change and become more relevant for patient care. The student had clearly moved very rapidly through the different aspects and levels of reflection. She had progressed from the descriptive to considering her own working relationships and practice towards the connective level where she was able to see how the theory she had learned related to practice and how her practice in the future could develop in the light of the theory.

In the session also with post-registration students on Atrial arrhythmias, Jane challenged the students to reflect on their own experience with patients and to consider whether they would change their practice in the light of the new knowledge they had been presented with in the session. Her approach moved students on from the descriptive and factual towards the more complex level of reflection where students were prompted to consider how their practice could develop in the future. Thus Jane and Mary encouraged students to address all four of the aspects of reflection that Fish et al (1991) identified. Strategies designed to develop skills of reflection and reflective practice in students drew upon sources of personal forms of knowledge in the form of the values and beliefs students held as well as propositional forms of knowledge or theoretical concepts. Reflection also encompassed process knowledge, professional artistry or professional craft knowledge (Higgs & Titchen 2001). Therefore the three forms of knowledge, personal, propositional and process which underpinned LP professional knowledge were clearly in evidence in the strategies the LPs used to enable and encourage their students to become reflective practitioners.

## Summary

The discussion has revolved around the key themes identified in the data. These came together around two significant areas: the nature of nursing, and the nature of LP professional knowledge. Each key theme was broken down into further sub themes and categories. The theme of the nature of nursing was significant in that it was the core content of what LPs taught students within their daily teaching activities. Each aspect of the nature of nursing, care, communication skills, ethical practice, and creation of a therapeutic environment, were discussed at length in relation to the data identified from the LPs. Similarly, the core elements within the nature of LP professional knowledge, role modelling, delivery of teaching, elaboration and guidance, and reflection were identified and discussed at length.

## Conclusion

The conclusions of the study were reviewed in the following section in the light of the aims, which were specifically to:

- document the forms of knowledge and skill that lecturer practitioners bring to the education of nurses
- understand the perceptions and experiences that lecturer practitioners have in their role in the education of nurses
- elucidate the distinctiveness that lecturer practitioners have in the education of nurses.

In order to address the aims the study undertook a detailed exploration of the lecturing aspect of the working lives of five individual Lecturer Practitioners. A case was built up of each LP utilizing data elicited from two semi-structured interviews and observations of two teaching sessions. Each case was unique, and presented a brief illustration of the lecturing aspects of the professional life of the LP concerned. This was set within the context of that individual's background and professional experience. The analysis of the data showed that in the lecturing aspects of their role the LPs demonstrated and embodied the intimate and symbiotic relationship between the practice and theory of nursing. Additionally, the further cross case analysis of the data demonstrated that there were characteristics of the lecturing aspects of their roles which were identified across all the cases.

### Form of knowledge and skill that LPs brought to the education of nurses

The data from the LPs highlighted that they were all in agreement about the key concepts of the nature of nursing. The theme of care was central to their conception of nursing and they affirmed that this encompassed emotional and psychological aspects as well as the physical care of patients. Communication skills were also a significant aspect of the nature of nursing and fundamentally this included non-verbal as well as verbal aspects of communication. The LPs asserted that ethical practice was a core aspect of nursing and this concurred with Freidson's (2001) ideas about the nature of professional practice. He stressed that there was the need for a professional to be trusted by their clients or patients and for the practitioner to have a moral commitment to his/her work. All the participants also saw the creation of a therapeutic environment for patients as an integral part of nursing. Clearly as individuals they had their own ideas about how they expressed their

personal conception of nursing. For instance, Mary saw co-ordination of services for patients as being a significant part of providing a nursing service and this in itself was part of the therapeutic environment she aimed to achieve for each patient.

**Perceptions and experiences that the LPs had in their role in nurse education**

The focus of the study was of five individual LPs who worked in one Higher Education Institution at a particular time. Each LP had a distinctive role within the institution in their lecturing contribution to various programmes in the faculty and in their specialist area of clinical practice. They had come into post just before the reviews of nurse education (DOH 1999, UKCC 1999) had reported their findings. Both reviews recommended that within the educational preparation of nurses for practice there should be a closer link between the theory and practice of nursing and they identified that the LP potentially had a pivotal role in putting these recommendations into practice. The study therefore took place at a particularly dynamic time in nurse education when the role of the LP was under close scrutiny.

The employment position of the LPs was also an important aspect of the context of the study especially in relation to the demands and priorities that the LPs had to manage in their daily lives. One of the subjects had remained in the employment of an NHS Trust and the remaining four of the LPs were employed by the HEI. All the participants identified serious tensions between the HEI and NHS organisations as far as the demands on them in their role were concerned. They felt that it was an enormous challenge to manage these demands in order not to be overwhelmed by them, and there was a danger of them being subjected to what might be called occupational schizophrenia.

**The distinctiveness that LPs had in the education of nurses**

The third aim of the study explored the distinctive nature of how the LPs taught students and facilitated their learning. This aim was also closely linked to the three forms of knowledge: propositional, process and personal. The findings coalesced around the theme of LP professional knowledge with further themes of role model, delivery of teaching, elaboration and guidance, and reflection.

As role models the LPs modelled professional behaviour in what and how they taught students. The way in which they related to students presented a powerful authoritative

image about how a professional should behave in practice. The fact that they listened to students, were flexible in their approach to teaching and clearly welcomed and valued students' contributions to sessions sent a message about their values and approach to people in general as well as specifically to students and patients. They also encouraged and enabled students to develop skills of critical thinking and through challenging them about their own beliefs and assumptions presented the role that they, the LPs, expected students as practitioners to take: to challenge norms and routines, and thus develop and improve practice.

The teaching methods the LPs used were highly interactive and clearly student centred. They encouraged students to engage with the material and concepts that were taught and to question and challenge when necessary. These approaches were likely to encourage deep as opposed to surface learning and had been acknowledged as being relevant and especially appropriate in higher education (Ramsden 2003). The LPs made observations about their own development as teachers from novice along a continuum towards becoming an expert. They all commented that having had some experience they were much more relaxed about teaching and that furthermore they now enjoyed teaching much more and felt that they were able to make their lessons enjoyable for students.

Within the analysis of the data and in relation to the interaction between students and lecturers, elaboration and guidance were distinguished as two overlapping concepts with different aspects and similar characteristics within them. Elaboration tended to be focused on the lecturer as features of theoretical, propositional knowledge were unpacked and related to practice. Guidance on the other hand was likely to be based on process knowledge and considered primarily how practice related to theory. The focus of guidance was essentially on the student and was thus likely to promote independence of both thought and action, whereas elaboration was more focused on the lecturer and could therefore produce a more dependent response in students.

The LPs aimed to encourage reflective approaches to practice in all students. They intended to enable students to progress towards more complex and deeper forms of reflection in order to develop their knowledge base and to enable them to challenge, change and improve practice.

As practitioners as well as lecturers the LPs were able to demonstrate a realistic understanding of the stresses and strains their students were subjected to on a daily basis working in the current health care system. They understood and were able to discuss the

reality of the demands of the modernisation of the NHS on practitioners for example the requirements of Clinical Governance or the penalties of breaching the waiting times in the Accident and Emergency Department. In their teaching they were able to rapidly, fluidly and seamlessly move between the two worlds of academia and practice. All the LPs demonstrated this fluid movement between two worlds but it was clearly demonstrated in the session Mary undertook with post registration students on pain. She was able to discuss with the students, one of whom she worked with on the ward in practice, how she used pain assessment tools in practice. She was able to link this practice (process) knowledge with the propositional knowledge of the physiology of pain and to reflect with the students what impact each form of knowledge had on the other and how this could improve patient care. Another example of the flawless movement between academia and practice was seen in the session Amy took with midwifery students on suturing. As she demonstrated the skill to them she constantly referred to her own practice and to how she sutured women whose baby she had delivered. At the same time she also referred to the propositional knowledge of the physiology of the perineum describing and discussing the function of the layers of muscle and skin that made up the perineal body. All the LPs felt that in order to provide an excellent and clinically relevant educational programme for students, nurse lecturers should regularly practice as nurses in order to keep their teaching up to date not only the content but also in the understanding of the reality of providing health care in the twenty first century.

**Recommendations**

Based on the findings of the study the recommendations are;

- That lecturers and LPs are encouraged to articulate what they consider to be the most significant issues within their specific professional discipline in order to be clear about what they teach to students.
- The purpose of the role of the LP should be clear for all organisations and people involved in nurse education, including students.
- Stakeholders within organisations involved with preparing students for practice, as well as lecturers and LPs, should consider the importance and impact of lecturers and LPs being role models for students. They should consider how this can be undertaken with authenticity and authority, presenting appropriate values and attributes of a professional practitioner to students.
- In order to enable them to fulfil their potential at the start of their career in nurse education, LPs should be supported in their role by peer LPs as well as more experienced lecturers.
- Similarly, in order to support LPs, programmes of professional education should be provided with specific elements designed to enable LPs to understand the importance of different pedagogical approaches in order for them to use the most appropriate strategies within their lecturing practice.

**Critique of the research approach and process**

At the end of the study the way in which the investigation was conducted was crucially evaluated. It was felt that in order to meet the aims of the study Case study had been a successful strategy for undertaking this particular enquiry. Case study has been identified as an appropriate approach when the focus of the research is to investigate how individuals function in their natural setting when the researcher had no control over the context of the study (Yin 1994, Denscombe 1998). This was clearly the situation in this study. Nevertheless there were issues in relation to the limitations of the research approach, which merited some further comment.

Case study is characterised by being assembled from different sources of data. In this study there were two main sources; interview and observation with documentary evidence being a secondary source in four of the cases. The balance between the data sources could have been presented in a different way or with a divergent emphasis. I felt that it was important to ask questions about the biography of each LP in the first interview in

order to explore how or whether their appeared to be anything obvious in their background that had influenced their values as a nurse and a LP. However values formation develops from such a wide and diverse range of influences it was difficult from the data collected to identify specific factors, which might have had an influence on them. The background information was intrinsically interesting and enabled the participant in each case to be presented as an individual however it could be argued that this information was not entirely necessary to meet the aims of the study. It could also be argued that more emphasis could have been placed on the data from the non-participant observations rather than the interview data as the focus of the enquiry was on the lecturing aspects of the role of the LPs. Decisions about the emphasis of the different sources of data as the cases were assembled were inevitably made in order to present what was thought to be a logical study which addressed the original aims. Other researchers might have made different decisions for equally valid reasons. However, as Holloway & Wheeler (2002) point out reflexivity on the part of the researcher in having a critically reflective perspective on the enquiry will increase the rigour of the study and will have an impact on the conclusions drawn from it.

## Areas for further research

As research is a dynamic process almost inevitably the conclusion of any research study will invite the possibility for further investigation. Following this study three immediate issues emerged.

Firstly, students' perceptions of the role of the LP could be explored. This could be undertaken using a survey to elicit views from a large number of students or a smaller number could be asked to take part in a focus group discussion or interview.

Secondly further investigation of the different roles in the support of student learning could be undertaken. This would specifically explore notions from Glenn & Clark (1999:18) who advocated the idea that there would be a dynamic approach to the role of supporting students with nurses being able to 'slip and slide between educational and practice arenas'. These ideas could be investigated in a number of ways utilising for example the different qualitative approaches of ethnography, phenomenology or a carefully designed action research study.

Thirdly a comparative study could be undertaken to investigate the differences between the lecturing practice of LPs and other lecturers this would directly relate to the findings from this study particularly issues around the distinctive nature of the role of the LP.

**Postscript: Where are they now?**

The LPs came into the University following a review of the profile of the staff teaching on nursing and midwifery programmes. All the LPs are now employed by the University and have developed their lecturing role in different ways and in various directions. They all remain committed to the notion of developing practice and practice-based knowledge but the demands of lecturing have meant that, currently, none of them have more than a twenty per cent time commitment to practice, which is the norm for all lecturers in the faculty.

Peter has now become a full time senior lecturer and his specialist area of practice is in Cancer Care. He is the professional lead for Cancer, Rehabilitation and Supportive care and he also contributes to teaching on Diploma, BSc and MSc programmes in the faculty.

Jane works part time as a senior lecturer, combining work with family commitments, and she has continued to develop her role in Coronary Care Nursing. She also contributes to the teaching and curriculum development of the Critical Care programmes within the faculty.

Mary has recently been promoted to Principal Lecturer and Director of the Continuing Professional Development Framework in the faculty with responsibility for developing and managing programmes from Certificate to Masters level.

Amy has changed the focus of her specialist area from Midwifery to School Nursing and she has recently taken up the role of professional lead for Specialist Community Nursing practice.

Ben now has the role of professional lead for Mental Health Nursing. He has recently been involved in the curriculum development on the Mental Health pathways in the Interprofessional Learning degree programme and the Continuing Professional Development programmes in the faculty.

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# Appendix 1

# Interview Schedules

## Interview schedule 1

- Where and when were you born?
- How would you describe your childhood?
- and schooling?
- Can you tell me about why and how you made the decision to become a nurse? What do you think influenced you in making this decision?
- Where did you train as a nurse? Why did you choose that training school and that training (adult, mental health etc.)?
- How did you feel about your training? What if anything did it give you over and above the actual qualification? Do you think that you developed personally as well as professionally during your nurse training?
- What further nursing qualifications did you undertake following your nurse training? Why did you choose this/these specialist courses?
- What academic qualifications have you undertaken? Why did you choose this /these specific courses?
- Briefly tell me about your career path in clinical nursing /midwifery practice
- Can you tell me what you think is important in/the essence of nursing?
- What sort of a nurse would you describe yourself as?
- What influenced you to consider undertaking the role of Lecturer Practitioner?

## Interview schedule 2

Think back and describe the first few lectures that you did when you first started. How has your practice changed since then? Can you illustrate this please

How would you describe your knowledge now? How and why has this knowledge changed and developed over time?

In the light of your experience how would you present this knowledge to students? Please give examples to illustrate.

Can you please answer the question My view of the purpose of what I am doing in education is....? What has influenced you in coming to this view?

What is distinctive about your role in the non clinical environment? What is it that you specifically give nurses in their educational experience that other lecturers are not able to provide? Can you illustrate this please.

What do you do now as a lecturer? describe to me typically how you do it.

What helped /facilitated your development as a lecturer in the role of lecturer practitioner?

What hindered your development as a lecturer in the role of lecturer practitioner?

What do you think are the rewards and satisfactions of the role of lecturer / practitioner?

Can you illustrate this please?

What are the difficulties and problems of the role? Can you illustrate this please?

# Appendix 2

## Key to the identification of Nature of Nursing themes in the data

Care

Communication

Ethical practice

Therapeutic environment

## Peter

### Biographical details

Peter described his childhood as 'golden', he said 'it was wonderful', he remembered playing on the beach and learning to swim around the harbour. His parents were brilliant with excellent parenting skills. It was not until he talked to other people that 'I realised just how lucky I was with my childhood'. He enjoyed school:

> 'I was very lucky to have such wonderful teachers that just turned me on to some ideas particularly from the fifth form onwards. Ideas exploded, in my life there were lots of things that I wanted to do, the main subjects I was interested in were History and Art.'

He developed a particular interest in politics and undertook a degree in Politics and Government. He graduated with a an upper second class honours degree and had a place to do post graduate research but funding for this was withdrawn at the last minute. He had been doing a holiday job at the local hospital and he got to know some of the nurses who suggested to him that he should think about nurse training:

> 'I thought well I'll give it a go, so I wandered along to the nurse education centre, asked for an application form, by this time I had hair growing out of every pore they didn't exactly welcome me with open arms at the reception desk. They asked me whether I realised that I needed to have some qualifications before I could start nurse training!'

Notwithstanding the fact that he may not have created the most favourable impression, shortly after he was interviewed he was offered a place and started training. He found the system of nurse education very rigid, it was modelled on what he described was an 'archaic school structure'. Within three months of starting his training Peter had not only become his group representative but also the student representative for the whole of the nurse education centre. He was part of a very cohesive and supportive student group which had an excellent tutor who made all the difference to how the rather poor curriculum was delivered.

Having started nurse training his motivation to continue was working with people at crucial points in their lives. He found that being able to **support** and **relate** to

people who were facing illness and life crises exhilarating as well as challenging 'it's wonderful working with people on this kind of level doing things for and with people and it's a socially useful job so it fits in ideologically'. On his first ward he remembered at least three occasions when a patient died and he realised that 'this was not playing at things'. He also recalled the time when a patient who he was caring for had a cardiac arrest. The ward sister coped with the situation as an expert practitioner, she moved so fast and so effectively 'she was being a nurse...it was an indication to me of there is a lot of depth in what is going on here its not simply, it's not a normal activity'. He saw expertise in action, he was very impressed with it and he wanted to emulate it. He was also aware of the stress and the psychological cost to the practitioner of working in that expert way. He thought that having to study and develop professional skills and expertise at the same time was more demanding than merely studying full time. He commented that nurse training made him grow up in a very real way:

Reciprocity Care

Professional artistry

Cost of care: 'emotional labour'

> 'University was an extension of childhood, nurse training was a maturing process I don't think it's just about an age thing'.

On qualifying Peter took up a staff nurse post in a ward working with patients who were being treated for cancer. It was an area that he had worked on as a student and for him: 'it was the essence of all the things I liked most about nursing, the quality of relationships, (with patients) the quality of teamwork, the buzz.' It was through working on that ward that Peter acknowledged that he became 'enmeshed' in nursing 'that's when I became pretty much totally committed to the idea of nursing'.

Communication

Care

Within two years he was in charge of the ward and then had the opportunity to work with a specialist consultant in a regional centre looking after patients with haemophilia many of whom had also developed HIV and AIDS as a result of being given contaminated blood products to treat their condition. At about this time (late 1980s) AIDS and HIV had become a major health issue and Peter became heavily involved with not only caring for these patients but also lobbying for change in the way in which they were looked after and treated by the NHS. He continued to work as the nurse in charge of the unit for several years, during which time he completed specialist courses and an MA in Health studies. As a specialist nurse he was increasingly being asked to lecture on an ad hoc basis to nurses and other

Advocacy

Care

health professionals at a Higher Education Institution (HEI) and a chance discussion with a course leader from the HEI led to him pursue the possibility of a joint appointment as a lecturer practitioner. One of Peter's watchwords is 'chance favours the alert mind' and it was the chance discussion which led him to change direction in his career and to look towards having a more formal role in teaching as a lecturer practitioner.

**Peter's conception of nursing**

Peter felt that nursing was principally about **relating** to people. 'the essence for me of nursing is **therapeutic relationship**' He was clear that the nurse should have a **psychodynamic relationship** with patients which was combined **with technical knowledge and skills**. He had a reductionist approach to looking at this, he felt that if the quality of the **relationship** was removed technical skills were all that was left and nurses were much more than technicians. 'If they don't have a **relationship** they are not nurses'. However, equally, he commented that the relationship on its own was not enough, **technical skills** were necessary for **healing interventions** to take place. He described himself as a psychodynamic nurse and he clearly identified that the nurse patient relationship was of paramount importance.

Communication
Therapeutic environment
Communication and Care
Communication
Communication
Care
Therapeutic environment

Peter's radical very strongly held political views led him to be passionately **concerned with people**, particularly those who were **vulnerable or in some way outcast from society**. His work with patients with HIV and AIDS epitomised this and had a deep effect on him, the **personal and professional satisfaction of working in that situation was profound: 'The ward that I worked on and the people I worked with I am just so proud of being part of that'.**

Care
Ethical practice
Care

Peter came into nursing having done a degree in politics and government, he felt that it was a socially useful occupation and he found it an absorbing, stimulating and rewarding career. Following qualification he was promoted quickly and spent most of his clinical practice working with patients who had HIV and AIDS. He strongly believed that nursing was primarily about **relating** to people. However, it also required a high level **technical knowledge** based on a deep understanding of the physiology of health and disease. His work with patients with HIV and AIDS convinced him of the need for nurses to **act as advocates** for their patients in order to be able to provide the high level of care that was necessary.

Communication
Informed care
Care / Ethical practice

**Jane**

Jane is in her mid thirties and works part time as a lecturer in Coronary Care Nursing and Clinical Science. She is small, dark and energetic; she smiles readily but there is a air of intensity about her. She recently completed a Post Graduate Certificate in Education (PGCE) and has started an MSc in Interprofessional Health and Community Studies. Recently Jane returned from maternity leave and started to work part time in order to balance the demands of family life with her career. Before taking maternity leave Jane worked full time as a lecturer practitioner in a coronary care unit and in the University College.

**Biographical details**

Jane was born and grew up in a small town in South Wales. She had what she described was a normal happy childhood, the only shadow was the several periods of unemployment her father experienced and she recalled the feelings of anxiety and stress that this caused for all the family.

When she was at university her grandfather became terminally ill, he was nursed in hospital by her neighbour. This event had a profound impact on Jane and ultimately influenced her career decision. She commented :

> 'seeing as she (the neighbour) cared for him and **how comfortable he was, and what a good death he had**, it sort of touched me, I think that you know, the **role that nurses could potentially have**.'

Care

Therapeutic environment

It was clear that Jane was impressed by what she saw of nursing and she realised what a difference **'good' nursing** made to her grandfather in the final days of his last illness.

Care

She graduated from university with an Upper Second class honours degree in Biological Science and obtained a job in marketing /sales in London in what she described as a 'high pressured cut throat environment'. She missed the contact with biological science which had been her great interest and she became more and more disillusioned with the work. When after two years she was made redundant she grasped the opportunity to change her career. She decided that she wanted to 'do something more human', to work with people in a more **caring environment**. It was then that she recollected how her

Care

well that her grandfather had been looked after and she resolved to train as a nurse. Jane felt that nursing was the antithesis of what she had been doing in sales and for her it was a '**revolt against the inhuman and impersonal world**' that she had been part of.

Care: human & personal

Following her training Jane worked on a medical ward as a staff nurse which also had a coronary care unit attached to it. As a staff nurse she particularly enjoyed contact with students and thought that ultimately she would like to develop her career as a nurse teacher. In spite of her relatively short time in clinical nursing three years ago she was successful in her first application for a post as a lecturer practitioner in coronary care nursing at a University College.

**Jane's Conception of Nursing**

Even though Jane has had a relatively short clinical career she had clearly formulated ideas about the nature of nursing. She believed that it involved a level of **technical competence**, (this was congruent with her background in the biological sciences) and that nurses should have a deep understanding of the natural sciences and this allowed them to create a **professional environment**. She declared that for her nursing meant that:

Competence

Knowledge/Therapeutic environment

> 'You are there for the patient to be relied on as the main point of contact, you are able to give them what they need in terms of **physical care. Patients look to you to do what is right for them**.'

Care

Ethical practice

She also identified the caring aspect of nursing in particular a willingness to **become involved with patients**. This meant that nurses must develop excellent **interpersonal skills** in order to be able to **communicate effectively** with a variety of people; patients, relatives, colleagues, doctors etc. She commented that for the time the nurse had with the patient and to some extent their family she was **one of the central people in their lives**. In support of this she claimed 'nursing means **connecting** on some human spirit level with patients, you are able to **touch and influence the lives of the people you are caring for**'.

Communication

Communication

Care, not just physical: emotional, psychological, informed care

It was clear that she placed great importance on both the technical rational and on the **interpersonal elements of professional competence**. This **holistic approach to nursing care** was exemplified further in her comment that '**nurses should be relied on to do what is right for the patient**' which involved '**nurses**

Communication

Care

Ethical practice

Care

touching people physically, emotionally and connecting on some form of human spirit level'. She commented that sometimes there could be a very intense relationship between patient their family and the nurse. However, more often patients' needs were more mundane and the relationship was less demanding, for example emptying a catheter bag or fetching the telephone 'it's a simple job, but for them that is something that is quite important, they've asked you for something that they need and you've met that need for them'.

Communication

Care

Care: more functional

Jane's ideas about nursing have emerged from her own experience and crucially from working with other nurses and observing how other they worked. She stated that her ideas had been developed by:

> 'looking at nurses that you respect and you see how one nurse acts with a patient and you think; that was really good that's how I want to be.'

'Basic' care

One of the people who had been a very positive role model for her was the ward sister she worked with when she was a senior staff nurse on the coronary care unit.

However Jane also commented that:

> 'sometimes you can learn just as much (about nursing) seeing someone who has left that patient in a real mess, or has handled a situation that I think well you haven't, you've not done them any favours here.'

Ethical practice
Therapeutic environment

As she further stated 'it's about positive and also negative role models which are probably as strong'. This indicated that she believed that both positive and negative images of nursing influenced her own thoughts and ideas about the nature of nursing.

Care

It became clear that Jane's conception of nursing had four key elements; technical competence (from knowledge and experience), physical care, emotional support which involves being there for the patient, and connecting with the patient (and their family) on some form of human spirit level.

Care

Communication

## Mary

### Biographical details

Mary was born in London and brought up in Surrey, she was the second daughter and the youngest of three children, her mother was a nurse and her father was a policeman. She described her childhood as fairly normal and happy.

Mary did not really know what she wanted to do for a career she felt that she wanted to do something that would give her a measure of independence and security. She therefore decided to apply to train as a nurse as soon as she could. She declared:

> 'To be honest I didn't know what else to do I had no idea what to do and it was in the family, and that it was that I had to do something with my life... I sometimes look back and think, I wonder if somebody had encouraged me to go on to university, maybe I would have done something different...you do sometimes wonder what else you might have been capable of.'

She also thought that she was subject to a certain amount of gender stereotyping and that both her school and her family had the attitude that nursing and teaching were suitable careers for girls and that medicine and dentistry were for boys.

She didn't really enjoy her nurse training but she did feel that it **enabled her to develop and mature personally** as well as professionally. She commented 'it gave me a lot of **insight into people**, I think **and maturity**.' She certainly enjoyed the social life and she was part of a very supportive group who had an excellent tutor who Mary said 'kept us on the straight and narrow'. She found that she **enjoyed looking after people** even though she did not feel that she had a 'vocation' to be a nurse.

Communication

Nursing care

Following her training she had what she described as 'reality shock', and felt that nursing was not what she had expected. So she left the profession to travel the world for three years. When she returned to England she got a job in an Intensive Care Unit (ITU) and to her surprise enjoyed the work. After a few months she heard about a new part time degree programme for qualified nurses which the local Higher Education College was running. She said 'I looked at the ad. and

thought, yes I'd quite like to do that, it suddenly occurred to me that I should go to university or whatever and do a degree, so I went straight into my nursing degree.' Over the next few years she worked as a staff nurse initially on ITU and then on a gynaecology unit. She found she really enjoyed the teaching aspects of her staff nurse's role. She thoroughly enjoyed studying for her degree and indeed described herself as being 'hooked on study' so, almost immediately after finishing her first degree she started a Masters degree. Mary felt that doing a degree was a highly significant event in her professional life, she declared that 'doing my degree did give me a lot of confidence and opened my eyes to things'. She felt that previously much of what was done in terms of **patient care** was based on **tradition and ritual** with very little questioning of **the rationale of the care being given to patients**. She was able to integrate the knowledge she gained from her academic studies not only with the care that she gave to patients, but also how she taught students and managed the ward.

Informed care

Competence

When she finished her Masters degree she decided to progress her ideas about moving into education and applied for her current post at the university college as a lecturer practitioner.

**Mary's conception of Nursing**

From several years as a practising nurse and from studying for two degrees in nursing Mary had developed her own personal concept of the nature of nursing. She was clear that nursing was about **caring for people**, but she felt that it **was more than just providing physical care**. It was about providing a **service for people** which was what she described as the **modern form of care**. She felt that nursing was the **co-ordination** of the **whole service** for individuals. Illustrating this idea she declared that the sort of thing that she would say to a patient would be:

Care

> 'Right I'm here, I'm your nurse, I'm here to provide for you, to look after you, to make sure your stay with us, **if you like runs smoothly**, that you get everything you need, that your appointments are kept, that you get your investigations that you require, that you get the treatment that you need on time.'

Therapeutic environment

She felt that the **attention to detail** in relation to what patients needed when in hospital was a **crucial part of nursing care.** For the patient it was often the

Care

apparently small and what might be seen as the insignificant things that they remembered about their stay in hospital. For instance whether their questions were answered in ways in which they could understand or whether they felt that the people attending to their most basic needs treated them with dignity and respect. Mary also felt that it was vital that patients had confidence in the people looking after them. To illustrate this she related an incident from when she had recently been in practice. A patient whom she had been caring for commented that she (Mary) 'gives the impression of being the one who knows, who's in charge and has got the finger on the pulse'. Without being conceited Mary found this comment gratifying and thought that it was just what she wanted to present to patients. She explained that sometimes she had worked with students who, because they themselves were novices and lacked confidence were not able to provide the ambience that patients needed. She had been able to put the patient and the student at ease. She illustrated this by saying 'you put your hand on the patient's hand and say it's OK, you know, and you almost feel them relax under your hand and you know that they have got confidence in you.' Mary felt that excellent communication skills were part of relating with patients and an essential component of good nursing care.

Communication

Ethical practice

Communication
Therapeutic environment

Care

Communication

**Amy**

**Biographical details**

To say that Amy's early childhood was unusual is an understatement. She was born in Colombo in Sri Lanka where her parents had stopped en route from England to South India. She was sent away from her parents to boarding school in India at the tender age of five. She said that she remembered feeling that 'it was quite a long way from them, it felt like an eternity'. She was eleven when the family returned to England where her father took up a post as a vicar. She left school at eighteen with what she described as two rather indifferent A levels. At first she was unsure of what her career path would be, however, after some deliberation she decided to follow her mother and sister to train as a nurse. She found the theoretical side of her training interesting and enjoyable but easy, particularly the physiology since she had done Biology at school. However she found putting the theory into practice more problematic. Her first experience of nursing

patients was on a female elderly care unit and the shock of what she experienced in terms of the **reality of the aging process was profound**: Maturing

> 'I was absolutely aghast that a human being got into that state at some point in their life I hadn't got even gone past thinking about people getting to be elderly and frail and incapacitated. It was a huge shock at the age of nineteen, absolutely soul distressing. I think even though I had seen an awful lot of trauma and human suffering in India, to see white people in that state was quite a shock.'

It was clear that **Amy's first exposure to suffering and infirmity was a watershed moment for her**; she was confronted with the reality of what was required to be a nurse. However, she was convinced that it was **'right'** and that she could **cope with it** and succeed in the profession. Care

As her training progressed Amy also had to face the fact that she **questioned** things too much for her own good, and that some of her superiors, she worked with did not approve of this: Communication

> 'I found that I questioned too much when I was training as a nurse and I didn't realise that until I was assessed that the sister in fact didn't like that and put me down, strongly put me down for questioning everything and I should just get on and do as I was told ...and that was a huge shock because I hadn't had any pre warnings that that was coming.'

Perhaps Amy's air of independence could have been interpreted as overconfidence was seen as something to be crushed or knocked out of her by those in authority over her.

**Amy's conception of Midwifery**

Amy believed that it was essential for a midwife to be **interested in people** and from that to **develop an understanding of people** claiming that: Communication

> 'I think being interested in people, for me is an essential aspect of wanting to be a midwife, wanting to be a nurse.'

She was also clear that it was essential to be **knowledgeable** about the midwife's role and to have **excellent communication skills**. She felt that as a Care Communication

midwife and to some extent as a school nurse she was able to exercise **autonomy** in her decision making which she had not been able to do as a staff nurse in the same way. As a midwife she was firmly committed to **providing care** that was **person and family centred**. Central to that she contended that the midwife should support women and their **families throughout the process of pregnancy, labour and for the first few weeks of the new baby's life**. She felt that the mother and her family should be able **to rely on the midwife as being someone whom they felt safe with**. This meant that the midwife must be **technically competent, confident** in her role and also be able to identify when she required further information or specialist expertise in order to provide **safe care**:

Ethical practice

Therapeutic environment

Care

Ethical practice

Care

> 'In a situation that's often incredibly frightening and unknown and to make them the mothers, the families feel safe so they can actually be fulfilled having a child whatever that might mean for them.'

She also felt that the midwife should be someone who was **honest** with patients and who **kept her word** to mothers. In a professional sense the midwife should be someone who would **act ethically** and who could be **relied upon** by mothers and their families. As she postulated 'if you don't know something, find out ... **and keeping promises**, if you say you're **going to do something, do it'**.

Communication

Ethical practice

Finally, she identified that it was essential for practicing midwives to keep up to date with modern techniques and developments. She commented that this could often be time consuming but that because of social and technological changes and the **dynamic nature of modern midwifery being informed of current research and developments was essential in order to be able to provide the best possible care**. Amy had developed these concepts about midwifery from her own considerable experience of working as a midwife with other health and medical professionals in a variety of settings in England and Australia.

Care

Ethical practice

**Ben**

**Biography**

Ben was born in Derbyshire and lived there all his life until he moved to the south of England three years ago. He described his childhood as average, he had a younger brother and his mother took time out from work as a teacher while they were both very young. He enjoyed school and always did well he was more of an academic student than his brother who was a sportsman. He studied biology at university and graduated with an upper second class honours degree. During the vacations he worked as a health care assistant in a mental health unit which specialised in the care of older people. He remembered that he found his **first exposure to caring for elderly confused people very traumatic** as he stated 'that very first day I was very close to walking out'. However, with the **support** of the other staff he gradually got to know the patients as people and to **understand their characters** and he began to **enjoy the work**. When he graduated he did not have any idea about career paths and he continued to work as a health care assistant. The nurse manager suggested that 'he should give nurse training a try' so eventually he thought that 'it would be something that would keep my brain active while I actually sort out what I am going to do'. As Ben had already had substantial experience in mental health care, that branch of nursing was the obvious choice.

**Care**

**Communication**

Ben stated that his training was poor, it certainly did not stretch him, academically and he was always at the top of his group. He wrote many of the assessments from a 'common sense point of view' and he was disappointed that more was not expected of him. As a science graduate he was astounded to find that there was very little physiology in the course 'it was striking that I was doing a nursing course and yet there was no physiology, you could probably, in three years squeeze the physiology into half a day'. He thought that he learned about practical skills when he was on placements but he was taught very little about the theoretical background to support practice. Nevertheless he felt that he did **develop personally** during his training even though there was nothing within the curriculum which facilitated this development. After he qualified he worked as a staff nurse but he already had clear ideas about his long term career aspirations:

**Communication**

'I didn't see being a clinical nurse, working on a

> ward or wherever as being a long term option for me ....I decided that I would have to take a particular route and I made that decision right at that very beginning and that route was always going to be education.'

He therefore, applied to do a Certificate in Education as soon as he could. He continued working as a staff nurse and was promoted several times, at one point he managed the ward for six months. More than ever he felt that education was the direction into which his career should ultimately develop and he was successful in his first application for his current post.

**Bens conception of nursing**

Ben believed that the essence of mental health nursing 'is really about your ability to be able to **communicate with people** and to have empathy with people and to be there in a genuine capacity'. He explained that he felt that people who came into hospital were facing a **strange environment**; they needed to feel that there was 'someone to actually **interact with them in a way that shows that you have caring within you'**. He developed this approach to mental health nursing from experience and from observing other practitioners. Sadly, he declared that he had **learned more from seeing bad practice** as he had seen some nurses who had become **immune to patients' distress and feelings about their illnesses**. He had also seen nurses who had used their position to exert power and control over patients, obviously more concerned about their own self gratification than their patients' needs. He affirmed that **care** was **not just concerned with the physical** but there was always an **emotional element** to it. He acknowledged that as a nurse you should be able to feel some of the pain and distress that the patient was feeling and be able to **empathise** with it without being overwhelmed by it. 'I think that some people can nurse and have a barrier there' He was convinced that patients have a feeling 'for where you are coming from as a person'. He felt that he had been able to make a **genuine relationship** with patients as he acknowledged 'I always felt that I was generally quite well respected by the patients themselves which was important to me'. He also identified what for him were the **'more tangible professional parts of the role'** in that he was a **very well organised person** and he deliberately created a particular **atmosphere** on the ward when he was in charge. He attributed this approach partly to his own personality 'I'm quite laid back generally' and partly to

Communication

Therapeutic environment

Care

Ethical practice

Care

Confidence

Communication

Care

Therapeutic environment

his **understanding of specific ways of dealing** with people who are **distressed or disturbed**:

Care

> 'I would **never contribute to escalating tension** on a ward which a lot of nurses did because of their **approach and their antagonism** and antagonistic way of dealing with people I always felt escalated tension and I **was trying to de-escalate it** and I think I achieved that and I know that feedback from people that I worked with is that they liked to work with me because the **environment the feeling on the ward** was **different** in a **positive way to what it was when they worked with other people**.'

Therapeutic environment

Ethical practice

He was convinced that each individual nurse had an influence on the climate or atmosphere of the ward and that they could influence it positively or negatively according to how they related to other members of staff and patients. It was clear that Ben also felt that nurses should have excellent **communication skills** in order to **provide the best care for patients**.

Communication

Care

# Appendix 3

## Key to the identification of themes in the data relating to forms of professional knowledge in LP practice

Role Model

Delivery of teaching

Elaboration and Guidance

Reflection

**Peter**

**Peter's principles of practice as a lecturer practitioner**

Peter had developed principles for practice as a lecturer from several years of working as a lecturer practitioner and from having done a PGCE. His principles for practice are summarised as follow:;

- to prepare and support student and practicing nurses in their educational needs
- to provide students with **cognitive and affective aspects of knowledge** they required for excellent clinical practice — **Elaboration and Guidance**
- through being a practicing nurse to be **a role model for students** — **Role Model**
- through education to prepare students to be thinking practitioners who would be able to be advocates for their patients.

Peter firmly believed that nurses must be able to asses the evidence underpinning service delivery so that their care was based on rationality not ritual. His role as a lecturer practitioner enabled him to reflect the reality of the **day to day dilemmas in practice using illustrations and scenarios from actual practice**. — **Role Model**

Peter had a facilitative style of teaching and he encouraged students to participate and contribute to his sessions. He appeared to have a very **open relationship with students and when they contributed or asked questions he always responded in a positive way even if this meant that the session moved away from his original plan**. — **Delivery of teaching**

He was keen to provide students with **appropriate physiological knowledge and it was clear** — **Elaboration and Guidance**

**that he had a very extensive understanding of the complexity of human physiology**. Within his teaching he constantly related specific physiology to symptoms of disease or specialist diagnostic tests in this way linking theory with practice.

Peter was also most concerned to **challenge students** about their preconceptions about diseases which people might view as socially unacceptable, notably HIV, or issues which nurses might not wish to address such as sexuality and older people. He **used discussion** backed up with epidemiological evidence as **a teaching strategy** to assist student to look at some of these issues. He also **used small group work as a way of facilitating discussion about issues which students might feel ambivalent or uncomfortable about discussing in a larger forum.** These strategies were a way in which the affective area of knowledge could be explored and re-appraised. Peter's frequent **reference to practice and to the uncertain and difficult conditions within which practitioners functioned indicated that he had a current and real understanding of the issues. He could be seen as a role model for students in that he as a practitioner struggled to deliver high quality care based on research evidence to patients himself and therefore he understood how difficult it could be for them.**

**Delivery of teaching**

**Delivery of teaching**

**Role Model**

**From principles to practice**

Two teaching sessions were observed, tape recorded and detailed ethnographic field notes were made of them. The first session was with a group of fourteen qualified nurses who were studying for the specialist course in cancer nursing. The second session was with a group of

twelve qualified nurses who were studying for a specialist course in the care of the older adult. Both sessions took place in well equipped lecture rooms which provided all the facilities necessary for teaching post registration nursing students.

**First session: immunology (using HIV as an exemplar)**

Peter introduced the session and explained what he aimed to cover, how it linked with what they had covered in the programme already and how it might link with future sessions. He was joined in the session by a lecturer practitioner colleague who had recently come into post from clinical practice. The students were undertaking the programme that Peter had personal responsibility for and on which he did most of the teaching. It was the eighth session of fifteen in this part of the programme so he and the students knew each other quite well. There was a considerable amount of good natured banter between Peter and the group, however there was never any doubt as to the fact that he was leading the session. At the outset he invited students to ask questions about Immunology as well as HIV/AIDS, one student asked 'is HIV/AIDS still on the increase?' Peter answered 'Yes it is' and he elaborated on the answer by using information from an acetate he had showing routes of transmission of the virus and the most recent information about the safe sex message with possible explanations as to why it is or is not being heeded. He then discussed patients who might be in units the students were working on and who would be being treated for cancer which they had contracted as a result of being immunocompromised by HIV. Peter then initiated a brief discussion about

Delivery of teaching

Delivery of teaching

Delivery of teaching

Delivery of teaching

Elaboration and Guidance

Delivery of teaching

Delivery of teaching
Elaboration and Guidance

international and national variations in relation to the incidence of HIV. He discussed example of incidence of the disease for example 60% of all cased in the UK are in London and in the Ukraine something like 80% of IV drug users now are HIV positive in contrast to 2% positive about seven years ago.

Delivery of teaching

Elaboration and Guidance

Peter then revised the physiology of how HIV affected the immune system. He drew diagrams and charts on the large whiteboard at the front of the classroom using the whole of the board while talking about the detailed physiology. The students commented at times but by and large they listened and made notes about macrophages, T4 cells immune system and T8 cells. They all appeared to be fully engaged with the session as they made notes and verbal contributions. He continued to expand the physiological illustrations while interacting with the students and encouraging them to contribute. He darted around the front of the room making points from his first diagram on the board in conjunction with the flip chart, the students laughed and bantered with him. His physical activity in the classroom as he made points emphasised his interest in the subject underlining its dynamic nature and the rapid progress that had been made in the treatment and management of the disease over a very few years. The students continued to ask questions particularly in relation to how HIV could affect their own patients, for example there was a discussion about dangers of using human sources for vaccine production. Peter continued the session by explaining in detail how HIV attacks the immune system linking the physiology with symptoms that may be evident. He also explained how viruses may cause cancer and how the immune system is affected in this. He

Delivery of teaching

Elaboration and Guidance

Delivery of teaching

Delivery of teaching

Elaboration and Guidance

continued to expand in detail the mechanism of the replication of the HIV virus with the aid of a further diagram and a handout; he explained what clinical markers were, the students made notes on their handouts. One student asked 'Can the HIV virus live outside the body?' Peter responded 'It can it depend on how you look at it, the vast majority of infective material will only live for half an hour.' They discussed the hazards of occupational exposure and of the best way to deal with things like needle stick injuries. Peter commented that 'most occupational health departments have a cocktail of three drugs that can be given to try to avoid accidental injury from resulting in infection with the HIV virus.' He outlined from the diagram on the whiteboard how the drugs worked, and why they had to be taken as soon as possible after exposure to the infection and, if possible, within half an hour.

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As the session continued Peter discussed recent treatments and management of the disease and compared treatment in the developed world with that in the developing world where HIV is a major health problem. All the time he linked the diagrams on the board and flip chart with information about the latest treatments and the mechanism of the progress of the disease, he also discussed the history of HIV and the current situation as to the mode of transmission.

Delivery of teaching

Elaboration and Guidance

There was comment and discussion about what people with HIV/AIDS actually died from as death is caused not by the virus but by other conditions (including cancer) which the patient developed as a result of a compromised immune system. Peter explained that the diagnosis of AIDS was only made when the patient was HIV

Delivery of teaching

positive and had one or more of twenty six identified illnesses.

Delivery of teaching

The discussion led by Peter moved on to consider the social results and implications of HIV, issues such as the 'gay plague' and there was an animated discussion about how governments proposed to deal with people who were HIV positive when the disease was first seen. There was discussion about so called 'leper colonies' for AIDS. There was a very lively discussion about the rights of patients with HIV and how society and the health care system should treat them. Ethical issues in relation to the testing of people for HIV were discussed as well as issues of consent and patients' rights in relation to informed choice and counseling before testing. Practice related concerns were raised by students, for example the need for strict adherence to taking universal precautions when looking after any patient. The issues of false positive results from testing were discussed and Peter demonstrated how this could happen by showing diagrams on the board and the flip chart. The session concluded with an exposition about the recent innovations in the treatment of the disease illustrating this with reference to survival rates now in comparison with five years or more ago. He discussed the fact that there were at least 20 different drugs on the market now for the treatment of HIV /AIDS. The fact that these drugs were powerful and may have untoward side effects was also discussed. Peter briefly reviewed what he had covered in the session and he invited further questions. As the students left for their tea break they were all discussing the session and commenting about how it had related to their practice.

Delivery of teaching

Elaboration and Guidance

Delivery of teaching

Elaboration and Guidance

Delivery of teaching

Reflection

**Second session: sexual health in old age**

This session was to a group of twelve post registration experienced nurses who were undertaking a specialist post registration programme in care of the older adult. Some of the students worked in hospitals in the NHS but several of them worked in privately run nursing homes. Peter had not met the students before and it was the ninth session of fifteen on the programme.

Peter **introduced himself to the students** and outlined what he intended to cover in the session. He started by presenting some statistics about the incidence of sexually transmitted diseases including HIV in older people and he asked the students whether the incidence of disease was what they would have expected. Generally the students indicated that sexuality was an issue in the care of older people that they did not think about very much.

Delivery of teaching

Peter then **asked the students to get into four groups and to work together for ten minutes on some case study scenarios.** Peter circulated around the groups and facilitated discussion and encouraged students to explore the issues.

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Peter had discussed the scenarios with the researcher before the session and stated that he had a deliberate strategy through the case studies to get students to identify for themselves what information they need to have for their own practice.

The students then started to give feedback from the case studies and Peter made notes of the salient points on the whiteboard. At first the students did not realise that the four case studies, which were free standing, also fitted together to form one overarching case. **This became apparent as the students gave feedback on each of**

Delivery of teaching

the scenarios. As the students saw that their case was part of a larger picture other issues emerged for discussion specifically relating to their own practice for example; legal issues, issues of consent and possible sexual abuse of vulnerable older people, confidentiality and ethical issues. These were all discussed at length by the group led and guided by Peter who provided appropriate information as necessary for example about legal issues or the ethical context of care. One student asked 'I just wonder where confidentiality ends with HIV, how long do you have to keep confidentiality?' Peter responded by saying 'That is a very difficult thing to answer because there are some legal guidelines but there's also some very big grey areas... where does the responsibility to the individual stop and responsibility to a larger group take over? And I think that the simple answer is that there is no clear line it has to be dealt with case by case.'

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Elaboration and Guidance

Role Model

Peter then led the discussion on to consider wider issues such as, normal sexuality and older people, challenging some popular myths and stereotypes.

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The session moved on to look in greater depth at issues related to practice such as whether institutions and those working in them could and should facilitate sexual activity for their residents. Peter also presented issues in relation to consent to sexual activity by looking at local and national guidelines and legal definitions. There was some animated discussion about this in relation to HIV and sexually transmitted diseases and how public health concerns could become an issue for those running and working in residential homes.

Role Model

Delivery of teaching

Elaboration and Guidance

The last part of the session were taken up with students

Delivery of teaching

asking Peter general questions about sexual health and HIV and AIDS particularly issues about mode of transmission of the virus and recent developments in the management and treatment of the disease. One student asked **'Could you explain the process from being diagnosed as HIV positive to being diagnosed with AIDS?' Peter replied 'Yes' and started to draw a diagram on the whiteboard. 'I am not very good at it but I like drawing!'; the students laughed. He illustrated the clinical markers that were seen in HIV and the progress to being diagnosed with AIDS. He continued to answer students' questions using the whiteboard to illustrate the answers.** The session concluded with Peter commenting that he hoped the students had found the information useful and wishing them well in their studies.

**Elaboration and Guidance**

**Jane**

**Jane's principles of practice as a lecturer practitioner**

From Jane's three years experience as a lecturer practitioner as well as from the Post Graduate Diploma in Education (PGCE) she had developed clear ideas which underpinned and informed her practice. From the interview data it is apparent that these principles of practice coalesce around the key areas summarised as follows:

- **to provide students** with the building blocks of scientific and technical knowledge **they required for practice** — **Elaboration and Guidance**
- to **encourage students** to take ownership for their ongoing professional learning needs — **Delivery of teaching**
- **through education and the development of reflective practice** to enable students to change practice and to improve patient care — **Reflection**
- **from current clinical practice to select appropriate case based material to illustrate and illuminate her teaching** — **Role Model**

At the outset Jane aimed to **provide students with knowledge and information** in the form of building blocks to inform and underpin their practice. She asserted that the knowledge and information that she was mainly concerned with was rooted in clinical science. She saw this knowledge as forming the foundations of the professional knowledge student nurses needed to function effectively in practice. Furthermore the application of this knowledge to practice emerged gradually as the course progressed and students were exposed to practice over time. — **Elaboration and Guidance**

Jane always sought to encourage students to identify what further knowledge, skills and understanding they needed to develop for their continuing professional development and learning in practice. As she noted:

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> 'In the light of the knowledge that maybe I've given but also the knowledge I've hopefully, you know, prompted them to think of, or facilitated them to seek.'

She hoped that by enabling students to develop ownership of their learning they would identify their own requirements for professional development an ongoing process. She realised that she might only be a small part of that process as it would require each nurse to formulate and negotiate their own learning path in the light of their particular practice. She declared that:

> 'hopefully at some point that information, that bit, will link up somewhere but it may not be linking directly through me, I'm hoping they are going to pick it up some other point and use that knowledge then in a meaningful way to practice.'

Each student would have to make their own connections about what forms of knowledge they required for practice and it would be the student who pulled it all together for meaning for their own practice.

Jane also hoped to change and improve patient care through the teaching of new knowledge skills. She affirmed:

> 'I think that's what I'm aiming to do is to hopefully make things, again it might sound a bit clichéd saying it, but it's about making the difference to patients... hopefully what they are learning is going to impact what they do, it's going to influence how they deal with things or how they

Reflection

work as nurses.'

Jane was convinced **that her recent experience of clinical practice enabled her to bring relevant real life issues to her teaching.** She felt that this was particularly important when she was teaching the post registration courses to experienced nurses. **She stated that her clinical background:** Role Model

> **'allows me to I suppose pick out those areas that information or what I'm teaching, to pick out those areas that are going to be directly relevant to that, so I think in terms of content it will have an effect, so I think that what I give is that, is that specialist knowledge which at the end of the day comes from adding current practical knowledge and I think that without that certainty, the very clinically based courses like the coronary care course, I think that if taught by somebody who wasn't as current as myself in clinical practice, I think the quality of that course would be worse.'**

She made an impassioned argument for **the case for lecturer practitioners' expertise in clinical nursing practice** as an essential requirement for teaching on clinical courses. She was able to **select relevant clinically based material to illuminate her teaching. For example when she taught the coronary care course about atrial cardiac arrhythmias she used examples of actual Electro Cardiogramm (ECG) tracings of arrhythmias from patients.** She emphasised the fact that coronary care and cardiac nursing was a highly dynamic area of practice which was constantly changing and she was able to **draw on materials from current practice as treatments changed and developed rather than having to rely on books and other secondary sources which would inevitably not be as up to date.** Role Model

Role Model

**First session: the physiology of the locomotor system**

This was taught to a group of 20 nursing students as part of a clinical science module at the beginning of the first year of their three year Diploma of Higher Education programme. It was a formal teaching session with Jane providing information to students about the normal function of muscles and joints. One of the main issues Jane identified was the variation in range of ability and of experience of study of the students and of the problem that posed for the lecturer. She had the challenge of maintaining the interest of those who already had advanced knowledge of the subject while at the same time not proceeding too fast so that the novices were left behind with the danger that they became confused and anxious. Jane commented that:

> 'there are some people with A level biology and some people who have never done it before or, worse than those who have never done it before, are those who have done a little bit before and have failed and now have this big fear about the whole thing.'

Jane employed **various strategies to overcome these problems, the first of which was to start the lesson with a quiz based on the subject covered in the previous session. This gave immediate feedback to students and was a positive reinforcement to them.** Delivery of teaching

The session was **mainly teacher led but interactive and was concerned with giving students information about the anatomy and physiology of the locomotor system.** She continued the session by **looking at bones and the skeleton, illustrating points on the flip chart and overhead projector**. Jane **asked** students questions Elaboration and Guidance Delivery of teaching

and encouraged them to ask questions of her. An example of this was that she asked 'What is a ligament?' A student answered 'they attach muscle to bone.' Jane replied 'ligaments actually attach bone to bone.' The question and answer strategy enabled students to develop their knowledge from the known to the unknown. This strategy was supported by an incomplete handout for students to fill in as the session progressed.

Elaboration and Guidance

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They then considered different joints, muscles, ligaments and tendons their function and action. Jane asked 'so which ligament does Gazzer have a problem with?' A student answered 'cruciate ligament' Jane said 'yes' and asked 'where in the body is the cruciate ligament?' A student answered 'the knee.' Jane agreed and then explained that it was called the cruciate ligament because it was cross shaped. The session then explored movement which required joints, muscles and bones to work together. Issues such as balance and co-ordination and the detail of how the nervous system worked together with the musculo skeletal system to facilitate movement were discussed.

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Jane then demonstrated flexion with a volunteer by moving his arm and reducing the angle of the joint. She asked 'what is the angle of this joint here?' The students answered '180 degrees.' She then moved the volunteer's wrist 'and now here?' The students answered '90 degrees.' Jane then said 'flexion is to reduce the angle of the joint.' Jane then continued to demonstrate various movements with the aid of the volunteer and with OHP slides giving the technical terms and degree of angle of movement. The whole process was accompanied by hilarity and comment from the

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students and it certainly engaged them in the learning activity.

What they had seen was followed up with further handouts about movement and moveable joints. There was considerable discussion about how understanding the physiology could affect the practice of nursing. The safe moving of patients was a major point. In a humorous way Jane illustrated this by asking students to consider the concept of stability in relation to whether a mouse or a giraffe had the more stable base and how this concept could be applied to how they moved patients in practice.

Delivery of teaching

At the end of the session Jane suggested further reading activities and open learning materials that students could work through to follow up the information she had given them.

Elaboration and Guidance

**Second session: atrial arrhythmias**

This lecture was to a group of seven experienced post registration students who were undertaking a specialist course in coronary care nursing. They were near the end of the first part of their course. The session was teacher led but students were expected to interact and contribute to the session. Jane started by providing a handout with different Electro Cardiogramm recordings on each sheet. The lesson was structured around the information on the handout. She asked the students to identify the recording on the first sheet and to give their reasons for their diagnosis. It was of a very simple ECG tracing showing normal sinus heart rhythm and all the students identified it easily. From the next tracing Jane asked 'What's going on there? any ideas?' The students looked blank so Jane said 'You

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know the session is on atrial arrhythmias so that gives you a bit of a clue. A student said 'sinus rhythm with atrial ectopics.' Jane said 'It is sinus rhythm with atrial ectopics. How did you know how did you work that out?' The student responded 'Erm... well if you take away the atrial ectopics you would have what would be a regular sinus rhythm with all the characteristics of a sinus rhythm.' Jane responded 'right' and nodded her head. The student continued saying 'but you are getting these extra premature beats coming in which are, erm... well, initially a different shape to the sinus rhythm.' Jane again responded 'right O.K.' The student continued 'and they are causing it to become irregular because of a pause after it.' Jane agreed with the response and summarised the main points that the tracing showed. She discussed the normal cardiac cycle seen on an ECG tracing and how premature ectopic beats could be identified. She challenged the students to provide the evidence on the tracing for their diagnosis and a general discussion ensued about how information could be seen on tracings. Jane then moved the session on to look at more complex recordings each of which was discussed at length and issues were explored in relation to treatment as well as diagnosis of conditions. It could clearly be seen that Jane moved the students on from simple concepts to the more complex. This was clearly a pedagogical strategy to encourage students to explore concepts and issues more deeply and thereby to develop a fuller understanding of the material. As each condition was discussed Jane outlined, with the help of OHP slides, the detailed physiology. She encouraged the students to discuss patients they had come across with conditions that were identified

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Reflection

and to think about how and why they had been treated in a particular way or with a specific drug. She thus enabled students to make connections between the physiology of specific cardiac conditions and the practice of nursing patients with cardiac disease. She clearly provided an arena for discussion and the opportunity for students to reflect on practice in the light of new or revised knowledge. She used case based material to explore the application of physiological knowledge to practice. For example she discussed her own experience of looking after a patient with Wolff Parkinson White syndrome (WPW). She asked the students 'what is the main way in which patients with WPW are managed?' A student responded by saying 'ablation' Jane agreed and said 'most patients with WPW what will happen is they will surgically ablate this pathway (indicating the pathway on the OHP slide) end of story, no more problems. What could be a complication of that?' A student responded by saying 'pacemaker.' Jane agreed and explained by drawing a diagram on the flip chart 'If you have got your pathway quite close to your A.V.(Atrio Ventricuar) node here the chances are that if you are taking out this bit of tissue out as well the whole thing goes so you will need a pacemaker.' She outlined how the patient she had nursed presented and was actually treated in practice as well as discussing different treatments that might have been used.

Throughout the session Jane was able to demonstrate her current knowledge of clinical practice by quoting examples of the use of specific drugs in practice and of specialised treatments for cardiac conditions.

Reflection

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Role Model

**Summary**

Jane came into nursing having done a degree in biological science. She had also had a high powered job for two years in a sales position, she found that nursing was a contrast to the cut throat environment and provided her with more personal job satisfaction.

She had clear ideas about the nature of nursing. She believed that nurses needed to have a thorough understanding of normal physiology and of the way in which disease and illness affected the human body. She also postulated the notion that nurses should care for patients and connect with them on some form of human spirit level.

As a lecturer practitioner Jane aimed to provide information in the form of building blocks of theoretical knowledge for students so that they would understand the physiology of illness and disease and therefore be able to look after patients in an intelligent way. She had an interactive style of teaching and expected students to contribute to sessions by reflecting on their own practice and personal experience. She used her own recent nursing experience to illustrate her teaching sessions particularly those with post registration students.

Delivery of teaching

Reflection

Role Model

**Mary**

Mary's principles of practice as a lecturer practitioner

From three years as a lecturer practitioner and having studied for a PGCE Mary has developed clearly formed ideas about the practice of nurse education and her role in it. The key issues she identified were as follows:

- **to produce knowledgeable competent practitioners by teaching the principles of specific aspects of nursing care** — Elaboration and Guidance
- to foster self awareness and an attitude of life long learning in students so that care was and continued to be based on best possible current evidence — Reflection
- to nurture and encourage students to continue to develop professionally and to influence and change practice
- **as a practising nurse to be a role model for students** — Role Model

**Mary's understanding of the way in which her educational experiences shaped her own practice gave her the impetus in turn to influence students herself.** She was clear that nurse education was a very practical form of education and that it should and could affect the way in which nurses provided actual patient care. She had been able to challenge traditional ways of delivering care to patients and thus to change not only her own practice but also the practice on her ward. — Reflection / Role Model

Another major feature of the way in which Mary functioned as a lecturer practitioner was to **encourage students to make the links between theory and practice and to change practice. She commented** — Elaboration and Guidance

**that 'sometimes they just need somebody to say, it's OK what you are doing, you know, keep at it and you're doing things well and it's very sad they don't get that in practice.'** She was very committed to the notion of professional development and she saw her role as someone who enabled students to critically review their practice and to identify what they needed from education in order to continue to function as effectively. She declared 'if every student nurse that we produce as a practitioner, if they think they've got everything they need for the rest of their professional lives, they are badly deluded.'

Reflection

**As a role model in practice Mary was able to illustrate her teaching from real life current situations she could say to students 'I was caring for this patient yesterday or last week, this is a real example from real life.' She argued that this ability to reflect on and use illustrations from practice gave her teaching a freshness and vitality that was very much appreciated by students.** She was also sometimes able to work on the ward with students she had taught and she found this particularly rewarding: **'for me it's kind of like putting everything together, its like saying, you know remember we talked about this in the classroom.'**

Role Model

Elaboration and Guidance

From principles to practice

Two of Mary's teaching sessions were observed and detailed ethnographic field notes were made. Both sessions were to post registration students who were qualified nurses undertaking further specialist study. The first session was a workshop and it took place in a teaching room in an acute hospital trust premises. The room was adequately equipped and had video and

overhead projecting facilities, however it was rather shabby and all the equipment was old and worn. In contrast the other session took place in a modern well equipped teaching room in the university college premises with overhead and video projector and all the latest equipment necessary for teaching nursing students

**First session: clinical supervision workshop**

The three hour session was taught to a group of three students. It was the last of a series of workshops developed by Mary specifically for the NHS Trust in order to prepare for the implementation of clinical supervision in all areas during the next year. — Delivery of teaching

Mary introduced the session and affirmed that would be informal and she would welcome contributions from any of them at any time. She invited the students to introduce themselves and asked them to state whether they had any experience of clinical supervision. One student stated that she had been on night duty the previous night and had not had any sleep since then (the session was from 1pm to 4pm!) so she would try to stay awake. — Delivery of teaching

She started by considering definitions of supervision and asking for students to contribute their own ideas. She wrote key points from the students such as 'supervising' on the flip chart. They discussed examples of what each point meant in practice. The session moved on to consider the definition from the nursing professional body of the term clinical supervision. — Elaboration and Guidance; Delivery of teaching; Elaboration and Guidance; Delivery of teaching

Mary then led a discussion comparing and contrasting the concepts of mentorship, preceptorship and clinical supervision. She affirmed 'We never stop learning or needing support at work to develop good practice.' Mary then explored with — Elaboration and Guidance; Delivery of teaching

students why clinical supervision was an issue in health care at the present time. **She and the students agreed that the Government's recent emphasis on the concept of corporate responsibility, accountability and clinical governance in health care delivery was the major factor**. Clinical supervision was seen by NHS managers as a way of empowering staff to be able to provide a high standard of care to patients. They **explored** how clinical supervision was a way of developing self awareness in individual practitioners and of how colleagues could be **constructively challenged to change and develop practice.** They agreed that clinical supervision provided both support and challenge for practitioners. The session moved on **to consider ways in which clinical supervision could be undertaken**. Each approach was **discussed in detail** and the advantages and disadvantages explored. The issue of who would be appropriate as a supervisor was also explored, and the problems that might be encountered when the supervisor was a line manager. The differences between **clinical supervision and annual individual performance review which was a line manger's role were examined.** The session **moved on to contemplate** legal aspects of clinical supervision, patient confidentiality and whether clinical supervision was cost effective. Mary **discussed the benefits of clinical supervision in terms of a reduction in sickness rates which could be measured and raised staff morale which could not so easily be quantified.**

Elaboration and Guidance

Delivery of teaching

Reflection

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The students then had a coffee break for half an hour before restarting the session. The student who had been on night duty was obviously very tired and kept on yawning but she appeared to be slightly more refreshed

after the break.

Mary restarted the session by reviewing what had been covered in the first part of the session. She stated that she would like to consider in more detail the issues in relation to the implementation of clinical supervision in each students' clinical area. She asked them 'what are your ideas about the implementation of clinical supervision?' One student answered 'people do not have time or the inclination to implement it.' Mary asked 'Why is that?' Another student responded 'because they do not know about it.' The discussion then moved on to look at how the positive aspects and benefits of clinical supervision could be communicated to other staff. Mary emphasised the need to change the culture of the ward environment so that all staff would be see the benefits of clinical supervision. Mary then moved the session on to look into the responsibility of the supervisee to prepare for the supervision session and whether supervisor and supervisee got on well and mutually felt that the supervision was beneficial. The issues of whether it was seen as a priority and something that staff supported each other in and covered for each other if necessary was discussed.

Delivery of teaching

Delivery of teaching

Delivery of teaching

Elaboration and Guidance

Delivery of teaching

Elaboration and Guidance

Mary then showed a short video clip about the different ways in which clinical supervision could be undertaken. The students then had a lively discussion about how some of the issues shown in the video could be applied to their own practice. Mary then provided a handout of a model of structured reflection and discussed with them how this could be used in practice. Finally she led an exercise about what sorts of things could be discussed at a supervision session and how to prepare for it.

Delivery of teaching

Reflection

Delivery of teaching

Mary then brought the workshop to a close by reviewing what had been covered in the session. She asked for comments from the students, thanked them for attending and asked them to complete an evaluation form before they left.

**Second session: management of pain in patients in acute care settings**

This session was with six post registration students who were undertaking a specialist programme in critical care nursing. The students were experienced nurses all of whom worked in the NHS in acute hospitals throughout the region. It was the tenth session of fifteen in the programme. Mary knew the students well as she had taught them for several of the previous sessions. Delivery of teaching

Mary introduced the session and outlined what she aimed to cover. She explained that the session would revise the physiology of pain and look at ways of managing pain. Elaboration and Guidance

She started the session by revising neuro physiology starting with nerve transmission. Delivery of teaching

Mary used the whiteboard to draw a nerve cell and talked through the structure of the cell and the way in which impulses were transmitted from a nerve to the central nervous system. Elaboration and Guidance

She questioned the students about neuro physiology and she quickly realised that the session would have to concentrate on developing the students' knowledge in relation to physiology rather than merely being a revision session. Delivery of teaching

Using the whiteboard, overhead projector and an expository and questioning approach Mary clarified anatomical terms such as 'Schwann cells' and 'Nodes of Ranvier.' The sodium and potassium pump, the role of electrolytes and the action potential were also Elaboration and Guidance

explored in detail. Mary then moved on to explore the link between the physiology of the nervous system and pain. She asked the students 'what is pain?' The students responded in unison 'what the patient says it is.' This was a definition from McCaffree (1999) which was commonly used and understood in nursing practice. Mary agreed and presented other definitions for the students to think about. They discussed the differences between a medical definition and nursing definitions. Mary emphasised the nursing definitions as those which took a holistic approach to why a patient might say they were in pain. One student raised the issue of how to deal with patients whose pain might not be 'real.' Mary and the other students challenged her about this idea and a general discussion ensued about whether nurses or other health professionals should make objective judgements about what is the subjective experience of being in pain. The discussion looked at issues such as whether patients might become dependant on narcotic drugs or whether some patients might need to be referred to a pain specialist. Mary suggested that nurses should consider alternative means to relieving pain rather than always assuming that patients needed narcotic drugs. One student commented 'I don't think that we do that enough do we?' Mary and the other students agreed. Another student described how he had seen effective pain relief strategies with self administered entonox being used. They then looked at other forms of patient administered pain relief or Patient Controlled Analgesia (PCA) and the fact that when the patient has control of their own means of pain relief they actually required less analgesia. They briefly discussed the psychosocial aspects of pain and pain

Delivery of teaching

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relief and the issues of patient support and empowerment. Mary moved the session on to explore the gate theory of pain as defined by Melzak and Wall (1991). This required students to apply their knowledge of the physiology of pain to understanding how the theory worked in practice. Mary explained with the aid of a diagram how the body manufactured its own opiates in response to pain. She encouraged the students to think about how they could use the theory with patients they had nursed to look at different ways to relieve pain. A student then animatedly interjected 'I mean that would make such sense, I didn't actually realise all that before I can't understand why we don't do more like massage. ' Mary nodded and encouragingly said 'uh huh' the student continued 'I always knew that there was scope for alternatives but I just think now why, why are we not doing more, why are we not touching our patients more? It's just - what are we doing? What are we not doing? What have we been doing?' Mary agreed and said 'It's amazing isn't it, you know it's just straight forward clinical things such like touching your patient, it doesn't have to be where the pain is necessarily, just the fact that you're touching them will send, will stimulate those fibres, will probably increase the secretion of serotonin and therefore will make them feel better anyway, even if it does not relieve the pain entirely. So that's the basis of why people feel better when they are stroked or massaged. So, yes, quite right, we probably don't make use of all the alternative ways of relieving pain we could.'

Elaboration and Guidance

Delivery of teaching

Elaboration and Guidance

Delivery of teaching

Elaboration and Guidance

Reflection

Role Model

Elaboration and Guidance

The session continued with Mary leading a discussion on how different drugs and mechanisms of pain

Delivery of teaching

control worked. She looked at a pain ladder and at the rationale for giving drugs regularly for example paracetamol in order to maintain effective pain relief. — Elaboration and Guidance

She then asked the students to do an exercise to look at how pain affected the physiology of different body systems and thus to relate the theory to practice. — Delivery of teaching; Elaboration and Guidance

The students worked together for ten minutes and then fed back to the whole group. Mary stressed the basic firm agreement from all the students that it is poor practice to leave patients in pain. She also emphasised that patients will have a slower post operative recovery time if they are in pain and that this would have an economic impact on the NHS. She also reinforced the notion of treating patients as individuals and not judging those negatively who appeared unable to tolerate what might be seen by the nurse as only moderate levels of pain. — Elaboration and Guidance

Mary and the students discussed the use of pain rating scales and she explained their use in the area where she currently worked. — Role Model

Finally, she asked whether they had any questions. Several students stated that they had found the session useful and thought provoking, they thought that it had been very relevant to their actual practice. — Reflection

**Summary**

Mary is committed to the development of practitioners through both education and practice. She had clear ideas about the nature of nursing and felt that practitioners should care for people and co-ordinate the services that patients required. She also emphasised that it was vital that nurses developed excellent communication skills so that they could assess and

develop strategies to meet patients' needs.

As a lecturer practitioner Mary affirmed that her role was to provide students with the principles of specific aspects of care and to illustrate the principles with exemplars from practice. She also felt that her role was to enable students to identify their ongoing learning needs in order to continue to develop as practitioners throughout their professional lives. Her teaching style was **interactive and** combined exposition of theoretical information with **question and answer strategies.** She was **flexible and had an excellent rapport with students, changing the focus of sessions if necessary in order to meet their needs.**

**Delivery of teaching**

## Amy

### Amy's principles of practice as a lecturer practitioner

From Amy's experience as a lecturer practitioner as well as from having completed the Post Graduate Certificate in Education (PGCE) she had developed ideas about her practice as a lecturer practitioner. They can be summarised as follows:

- **to provide students with the knowledge necessary for competent midwifery practice notably physiology and the theory and practice of effective communication with people** — Elaboration and Guidance
- **to enable students to understand the theoretical concepts underpinning practice and therefore to apply theory appropriately to practice**
- to enable students to develop as questioning critical thinkers, and reflective practitioners able to influence and change practice — Reflection
- **to direct students to relevant practice related information sources** — Elaboration and Guidance
- **as a practicing midwife to be a role model for students** — Role Model

Amy was **concerned to provide students with knowledge that they required for competent safe practice. She identified that a key area was knowledge of physiology particularly of the normal reproductive system and the physiological processes involved in pregnancy and childbirth**. Amy thought that students required not only to have the knowledge necessary for practice on the day that they qualified as midwives but also to be able to continually update and — Elaboration and Guidance

refine that knowledge as necessary throughout a lifetime of practice. They would then be in a position to critically evaluate the evidence upon which their practice was based. Amy was keen to emphasise the **links between theory and practice** and her very strong view was that her current role as a practicing midwife, albeit part time, enabled her to **demonstrate these links** by **using exemplars from her everyday practice to illuminate her classroom teaching.**

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Amy **actively encouraged students to challenge and question her in class and in turn she challenged them to produce evidence to support their ideas and perceptions**.

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In her classroom management Amy was a **role model demonstrating how she expected students to conduct themselves in practice.** She was clear that her role was to enable students to develop as **questioning critical thinkers, able to change and influence practice**. Through her own **assertive questioning stance she empowered students to be able to question and challenge practice. The classroom provided a safe environment where students could rehearse arguments and explore ways in which to challenge assumptions about clinical care.**

Role Model

Elaboration and Guidance

Role Model

**Vitally, Amy felt that her work as a clinical midwife authorised her to demonstrate her familiarity with the real world of current practice in her classroom based teaching.**

**First session: perineal suturing**

This was taught to a group of eighteen midwifery students who had completed eight months of their eighteen month

degree programme. All of them were qualified nurses and some had had extensive experience as nurses in a number of specialist areas. The aim of the session was to provide knowledge and simulated practice of perineal suturing. Amy **combined a formal teaching strategy with demonstration, extracts from a video and a very informal interactive practical activity designed to enable students to practice suturing. At the outset of the lesson Amy indicated that it would be interactive and that she would expect all students to practice using suturing material.**

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She started the session by **asking the students about their experience either personally or professionally about suturing or having been sutured.** She asked whether anyone had sutured wounds when working in an Accident and Emergency Unit and **a brief discussion ensued** about how this might be different from suturing patients in midwifery.

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**Students who were also mothers contributed to the discussion and there was agreement about the need to respect privacy and for the process of suturing to be undertaken with skill and sensitivity. She emphasised the necessity for obtaining consent from women for suturing as would be required for any invasive procedure. She raised the issue of pain relief for the procedure and cited recent evidence that women experienced severe emotional and psychological trauma as a result of inadequate pain relief. The students were then shown a short video of the important issues in suturing including detailed anatomy of the perineal area following delivery and of the importance of correct suturing technique to enable the perineum to heal as quickly as possible.**

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This was supported by evidence on the video from research that had been done on perineal healing. The students were obviously interested in the video and listened attentively and discussed issues in groups when it was finished. Amy emphasised the main points from the video for example the importance of locating the apex of the episiotomy or tear, the need to keep the suturing field sterile and the difficulties of this when opening a pack of suture material.

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She reminded students about the relevant physiology and she drew their attention to the connection between a knowledge of the physiology and how suturing should be undertaken.

Amy then divided the group and half worked with her and half with her colleague. She gave students materials for practicing suturing and she demonstrated key points, for example how to hold a needle holder, how to remove the thread on the needle holder from the sterile pack without it becoming contaminated. All students then practiced with Amy or her colleague checking and advising each student. The lesson continued with Amy demonstrating different aspects of suturing and the students then practicing and the lecturers advising and assisting as necessary. All the students were fully engaged in the activity all practiced and were able to discuss their technique with Amy or her colleague. Amy then replayed part of the video and students were able to compare their techniques with the video.

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They then were able to ask questions about technique and specific issues for example a student said 'but I am left handed' Amy answered 'If you are left handed use your left hand to hold the needle holder

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and adapt as you would when doing a delivery.' She commented that 'left handed people, I think from discussing it with colleagues, you have to take the needle out of the packet and reposition it for a left handed person around the other way.'

Amy then demonstrated actual suturing on a model and she talked through what she was doing. She made frequent reference to what she did in practice for example as she had small hands she showed them her own technique for holding the needle on the shaft of the holder which was rather different from how they might have seen other people holding it with a scissor hold. They discussed the differences between vaginal wall, muscle tissue and skin. The students then continued to work on their own models while Amy made positive comments such as 'yes lovely, well done' as she saw what they had done with the suture materials. She corrected some students and she reinforced the practice of what they were doing with the needle and suture material: 'don't forget we have got a semi-circular needle so use the shape of the needle to go in and come out.'

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Role Model

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Amy's frequent references to her own practice emphasised her principle of being a role model for students as a practicing midwife. She commented on the realities of practice and the difficulties of, for instance, how the suturing of a tear differed from suturing an episiotomy.

Role Model

After all the students had practiced suturing Amy drew the session to a close she reminded them about practice materials that were available for them to use in the clinical areas and that the video that they had seen was in the library for them to borrow.

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**Second Session: male and female reproductive systems**

This session was to the same group of student midwives in the same well equipped teaching room. The session lasted one hour and it proceeded at a **brisk pace with students being fully involved in the learning process.**

Delivery of teaching

Amy introduced the session and discussed the need for midwives to have a **detailed comprehensive knowledge of both male and female reproductive systems.** She stated that she had made the assumption that they would already have detailed knowledge of the male and female reproductive systems from their previous studies, **so that the current session should just be revision. She gave the students a very detailed incomplete handout of the male and female reproductive systems and she suggested that they worked together in pairs for ten minutes to complete it.** The students worked together and there was a buzz of discussion in the groups as they completed the handouts. Before providing the answers Amy asked the students about **whether they had felt that this exercise had been worthwhile** and easier or harder than they thought it would be. One student commented 'it was much harder than I had thought it would be' and one said that 'it was worrying that I did not know it all.' Several students appeared to be discomfited by their own lack of knowledge of the subject and there was some embarrassed laughter about the fact that they were nearly half way through their midwifery degree without being able to demonstrate that they had a comprehensive knowledge of the basic anatomy involved in human reproduction. It was **clearly an effective strategy** to enable students to assess their own learning needs and it

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was one which the students found very worthwhile.

Amy then provided the answers to the handout on the overhead projector. She first provided a detailed explanation of each part of the female and then the male reproductive systems. There was discussion of the anatomical similarities of the female clitoris and the male penis. There was also discussion linking the anatomy of the fourchette with the session on suturing they had undertaken the previous week. Issues from practice such as subfertility and undescended testes were commented on. She asked students 'what is one of the tests a paediatrician will do when examining the genitalia of newborn baby boys?' A student responded 'they will check to see if the testes have descended.' Amy said 'yes and if they have not descended what happens usually with a newborn baby?' The student said 'they will wait a while especially if the baby is pre-term but if they do not descend then they will have to be operated on.' Amy then challenged them to explain the action of the 'morning after' pill and also to identify why prostaglandin found in semen might mean that intercourse triggered labour to start. There was a lively discussion about the links between the anatomy and physiology of the female reproductive system, conception, pregnancy and labour.

At the end of the session Amy told the students where they could find further information about the subject by providing a reference list for them. She urged them to ensure that they made up gaps in their knowledge that they had identified as a result of the session.

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**Summary**

Amy's first experience of disease and suffering was a watershed moment. She was shocked by suffering but she knew that she could cope with it. She worked for several years as a nurse in a range of health care settings, combining work with being a wife and a mother. Amy then trained as a midwife, an area of practice she found hugely demanding but enormously rewarding. After she qualified the family lived and worked in Australia for two years and she was able to develop her skills in a different environment.

Amy thought that her role in midwifery education was to work with students as a **facilitator of their learning**. As a **role model she challenged them to provide sound arguments for any proposed course of action and she expected them to challenge her if necessary.** She worked systematically and **devised strategies for enabling students to identify their learning needs and deficiencies and to develop ways to meet these needs.** She constantly strove to **link theory with practice by giving exemplars from her own practice** and she **prompted students to reflect on their experience in relation to the theory underpinning practice.**

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**Role Model**

**Elaboration and Guidance**

**Role Model**

**Reflection**

**Ben**

**Ben's principles of practice as a lecturer practitioner**

Ben had developed principles for practice as a lecturer practitioner from his experience as a part time lecturer, as well as working as a lecturer practitioner and from having completed a PGCE. They are summarised as follows:

- **to improve students' understanding of how theoretical concepts (mainly science based) related to the practice of mental health nursing**
- **to enable students to work with that knowledge, to develop and change practice**
- **to enable students to understand the nature and pharmacological action of the medications they would be administering to patients**
- **to enable students to understand the nature of specific illnesses**

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**Reflecting upon the almost non-existent science content in his own nurse training Ben affirmed that having a thorough understanding of science and specifically biological science was vital for nurses to be able to provide the care necessary for patients in the twenty first century.** He had a particular interest in pharmacology and in understanding how drugs worked on the brain. He felt that it was vital that nurses who were administering drugs had a clear understanding of how they worked and of how they might interact with other substances in the body.

**Reflection**

Ben had a **very professional, interactive style of teaching,** in his sessions he **expected students to question him and he questioned them.** He frequently

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asked them to think about what they had seen in practice and to identify how it related to the theory he had presented to them. Reflection

**From principles to practice**

Two teaching sessions were observed, they were tape recorded and detailed ethnographic field notes were made. Both sessions were with the same group of students, Ben had built up a good relationship with them as he had been teaching them on this part of their programme for the last four months. The sessions were taught in annexes of the main part of the institution, the first session was in a well equipped informally laid out teaching room, the second session was in rather a small room which was not well equipped and which was badly affected by traffic noise from a busy road.

**First session: inorganic disease - management and treatment of depression**

Ben introduced the session by reviewing what had been covered last time they met which was a few weeks ago as the students had been undertaking clinical placements away from the University College. He commented that they would be able to reflect on what they had seen in practice in relation to the physiology of diseases that they would be looking at. He asked them to think about specific clients/patients that they had looked after and to ask questions as the session progressed. Delivery of teaching Reflection

He confirmed that the session would focus on the underlying physiology of depression and to examine how and whether current practice was based on evidence. An example of the question and answer Elaboration and Guidance

strategy employed by Ben was as follows: Ben asked the group 'what are the main features of depression? Is depression an illness?' A student responded by saying 'It can be.' Ben asked 'what is depression about?' Another student responded by saying 'there is reactive depression, something happens and the patient reacts to it by becoming depressed.' Ben agreed and said 'some patients are subjected to experiences for example bereavement which causes them to become depressed.' Ben then asked 'How do we treat depression - in terms of neurobiology?' Several students answer 'antidepressants.' They continued to discuss treatment methods and then Ben moved the session on to discuss mood and the difference between 'Monday morning blues' and depression. They then discussed suicide and self-harm as a serious consequences of depression. Ben emphatically stated 'don't ever let your guard down,' and cited evidence which suggested that a patient who was depressed and who expressed suicidal thoughts may well commit suicide at some point. He linked the issue of depression with the Government's Health of the Nation targets, one of which is to significantly reduce the numbers of deaths from suicide over the next few years.

From recent studies Ben outlined the arguments concerning predisposing factors to depression, and reviewed the nature nurture debate. He confirmed that physiological changes could be identified in the brain of patients with depression no matter what had caused the depression.

Ben then moved the session on, changing his teaching strategy by showing slides examining the

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biological genetic basis of mental illnesses. The first few slides showed a continuum of genetic loading of diseases, schizophrenia having a high genetic loading, Post Traumatic Stress Disorder (PTSD) having a low loading, and depression having a mid genetic loading. The students took notes from the slides about symptoms of depression, for example loss of sleep, loss of libido, either weight loss or weight gain, patterns of thinking, for example pessimism, suicidal or homicidal thoughts or impulses and self neglect or self harm. One student asked about optimistic and pessimistic personalities 'Is this when we talk of the glass half empty or the glass half full?' Ben agreed that there were people whose personality predisposed them to being pessimistic or optimistic and that this could be related to whether they were likely to become depressed. Continuing with the slides Ben expanded upon the illustrated risk factors in relation to age and gender for depression with women at higher risk between 20-40 years of age and men at greatest risk over 65 years of age. He affirmed the evidence shown on the slides that married women have a higher risk of having depression than those who are single and that the evidence is the reverse for men, however, women following pregnancy had the highest risk of all. They discussed the validity of treatments for depression and he showed a slide which emphasised the cyclical nature of depression which may continue for years or even for life. Ben then showed a slide demonstrating the strong evidence from trials that it is better to treat depression for the long term outcome for patients than not to treat. Ben confirmed that drugs such as Prozac have been used very widely and that they

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were powerful substances which altered the brain chemistry and they should be used with great caution. He emphasised that in order to reduce the possibility of any side effects they should be withdrawn very gradually. In relation to the use of Electro Convulsive Therapy (ECT) for the treatment of depression he stated that its mode of action was unknown. He commented that 'drug companies have done research so it must be viewed cautiously but it does seem that keeping people well on ECT alone is less likely than in combination with medication.' Ben continued to show sides of the mechanism of the action of antidepressant drugs showing the physiological changes which the drugs brought about. He encouraged students to comment on what they had seen in practice in relation to the treatment of depression. The session moved on to explore drugs commonly used in the treatment of depression, older and newer drugs and their side effects. For example patients taking Monoaimine oxidase inhibitors (MAOI) must be aware of untoward and serious side effects if they ate certain foods. As an illustration of what that might mean in practice Ben noted that 'patients on MAOIs must not eat cheese sandwiches!' Ben affirmed that it was vital for nurses to be aware of possible drug interactions and side effects such as drowsiness, constipation or unsteadiness, it was particularly important to have this knowledge when looking after older people who may be frail and or confused. He acknowledged that the newer drugs worked more selectively and were know as 'cleaner' as they had fewer side effects.

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Ben concluded the session by asking whether there were any questions and asked the students whether they

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had found it helpful and enabled them to understand some of the issues in the treatment of depression. The students responded very positively one stated 'it has been helpful' they left the room with some of them still talking about issues covered in the session.

**Session two: organic illness; Alzheimer's disease and dementia**

Ben introduced the session outlining what he intended to cover. He asked students 'what do you understand organic illness to be?' Two students replied 'irreversible condition', 'dementia.' Ben agreed and acknowledged that it was important to differentiate between an irreversible condition which would continue to deteriorate and a drug induced psychotic illness which might improve as the effects of the drug wore off. In the current session he would concentrate on exploring the physiological changes that occur in the brain with organic illness (dementia) which are permanent and progressive. He stated that it was important to identify what occurred in the normal aging process and how dementia differed from this.

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He then asked them to work in groups for five minutes to consider the differences between normal aging and dementia. They fed back the main points and Ben summarised them on the flip chart. There was then a lively discussion about why this should be, issues such as genetics or injury or lifestyle factors were discussed with nature versus nurture being vigorously debated.

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Ben then provided information about the incidence of dementia and he stated that in over 80 year olds the incidence is 20-25 % and he affirmed that the older a

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person becomes the more likely they are to become demented; approximately 800,000 people in the United Kingdom had the disease. He explained that dementia affected the cerebral cortex of the brain. Using the whiteboard as a visual aid he explained the physiological changes that occurred in the brain in patients with dementia. He stated that there was a build up of plaques and tangles in the brain tissue causing its permanent destruction. A provisional working diagnosis would usually be made based on clinical symptoms the patient displayed but it could only ever be confirmed at post mortem. Ben illustrated by drawing on the whiteboard illustrating the way in which beta-amyloid proteins in the cerebral cortex wrap around to form plaques and yellow bodies which shrivel around plaques and lead to cell death. Tangles are caused by excess TAU proteins which also leads to cell death. He affirmed that the latest research into treatment were exploring the possibilities of reducing beta amyloid proteins in the brain. Ben explained that a drug called 'Aricept' was being used to treat dementia, its action was to inhibit the breakdown of acetylcholine which was known to be linked with memory, so the symptoms of memory loss were treated but not the underlying cause. Ben and the students discussed the ethical dilemmas and issues involved in using the drug. For example, Ben asked 'when do you stop using it? How is that decision made and who should make the decision?' He asked 'can you put a price on quality of life?' He and the students discussed whether the drug raised false hopes in patients or their families and what the role of the nurse could or should be in all of this. As the drug only masked the progress of

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the disease when it was withdrawn there was often a rapid deterioration of the condition.

Ben then moved the session from the examination of physiological issues to consider the reality of dementia for patients, for their families and for nurses. It was agreed that there were some similarities to caring for patients with dementia with patients who were being treated palliatively for a terminal illness. In each situation it was the quality of life that the patients had that was of paramount importance as in neither situation would there be a cure. Most of the students had nursed patients with dementia and Ben very sensitively and with great insight explained the reality of the disease. 'For a patient with dementia they will forget who they are, who their loved ones are, communication will be disrupted, there may be the risk of injury, there will be a loss of independence, a loss of dignity, a loss of autonomy and a loss of insight and awareness.' He commented 'all these symptoms pose great challenges for nurses to provide the highest quality of care for patients.' As he explained the symptoms with illustrations on the whiteboard the students were attentive and interested, they contributed from their own experience both personally . and professionally. On the whiteboard Ben provided the technical terms for the symptoms and gave examples of how they were seen in patients. Often patients with dementia lose the skills they have for daily living. Nurses must be able to help them with these to preserve their dignity and individuality often in difficult situations where patients may be aggressive because of frustration at not being able to

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communicate effectively.

Ben ended the session by saying to the students that 'excellent nursing care is vital it requires a very high level of communication skills from nurses to find out what patients needs are and to support them. I will leave you with that thought.'

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**Summary**

Ben came into mental health nursing having completed a biological science degree. He believed that nursing required practitioners to develop excellent and effective communication strategies with patients and their carers. As a practitioner he deliberately set out to create a positive atmosphere in any working situation. He felt that people who were distressed and disturbed needed to be cared for in a calm environment which would facilitate therapeutic intervention and treatment. He firmly believed that mental health nurses should be able to combine a thorough understanding of physiological issues with nursing expertise.

Ben believed that his role as a nurse educator was to enable students to have a thorough understanding of the physiological background to different aspects of nursing care. He thought that it was crucial that students were able to understand how disease affected the person and those close to them. As a nurse educator he valued students' life and practice placement experience and used it as a vehicle for them to reflect on what was being taught in the classroom. He had an interactive teaching style frequently using a questioning technique; he also used different pedagogical strategies to enable students to maintain their concentration and interest.

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**Appendix 4**

# Raw data from interviews and observations with Amy

This is the first interview with Amy. So thank you Amy for taking the time to be interviewed for this research. Just to let you know that the interview will take about 45mins and its in three parts. Firstly are the questions about you as a person, leading up to when you decided to become a nurse, then there are questions about your career as a nurse, I should say nurse and midwife, and finally there are some questions about your principles and practice as a midwife. Is that OK?

That's fine.

Good, good. So starting at the beginning, when were you born?

I was born in 1957, June, in Colombo in Sri Lanka.

Wow, in Colombo. There must be a story behind that somewhere.

There is, well my Dad worked for Church Missionary Society, it was his first posting with the CMS and he wanted to work in India and he was, my mother was pregnant with me and CMS said you are not going yet, when you've had the baby and my parents said, no we are going, so they went off and they had to stop at Sri Lanka ... as it was for me to be born, so we were there fore 6 months and then moved on to south India where he worked as the Treasurer of the ... south India until I was 11.

Really.

Then we came back to England.

That must have been a big culture shock.

Coming back to England was a huge culture shock yes.

Do you have any brothers or sisters. Yes, I've got an older sister, she was born in England, she's 18 months older than me, in Southport, and a brother who is just over 2 years younger than me, he was born again in South India and sister whose 5 years younger than me born in South India.

So four of you, one boy and three girls. So the next thing I was going to say is can you tell me significant things about your childhood? It must have been a very, different childhood. Did you come home to England at all?

We came home in 1962 and 1965, had 6 months sabbatical with my father, apart from that we were in India and I went to boarding school when I was 5 in India.

How far away from them?

It was about, quite a long way, it felt like an eternity.

I'm sure.

It was just what happened really, but in retrospect very traumatic.

Yes, yes.

Hugely traumatic.

Really.

Well that was the dilemma, for my parents really, did they send me back to England for boarding school or in India boarding school and they chose to keep me in the country that they were in. But we only saw then on holidays, so it, we should have probably been in more contact than coming to England, but maybe it would have been wiser the other way.

Difficult.

It is difficult because education wise, Indian education failing the English 11 Plus because I wasn't prepared for it and then heading back to this country with a failure over my head, being placed in secondary modern and then because my Dad moved jobs to get his own Parish, I was placed in a school that was going to be comprehensive so, which was very good decision as such and of course, and the schools, in a grammar school rather than move again

It is interesting isn't it. So you came back to England when you were 11. And you lived?

We lived first in Southsea for about 4 or 5 months, Hampshire and then moved to Derbyshire in '68 and my parents were there until '74 and I stayed until '75 to do my A'Levels, not with much success and.

Without much success?

Without much success, I managed to get 2 out of the 4.

That's not bad ...

Yes. They were appalling grades for what I could have achieved. Again I think a lot of it was the schooling mixture and all sorts.

So that was really quite a feature of your childhood, the sort of isolation, moving.

Yes.

My Dad moved jobs again to South London but for another Missionary Society after having a Parish, being the village Priest and I refused to move and stayed to do my A'Levels. So with no parental push I just did not achieve. I may not have achieved with parental push, so at that point it was the digging the heels time. Again that respect I should have perhaps done another 2 years and started 6th form again, but I wasn't going to.

That would have been very difficult at that age.

Yes, so I had a year out after A'Levels, did a 2 week holiday in Egypt and met, it was the Church Missionary Society holiday group, met somebody there who was a nurse and just chatting to her thought, right perhaps I will be a nurse and then if I go to University I will have a whale of a time and do no work. So unfortunately nursing in those days was you

were pushed along to do that job, so I did that one. My mother is a nurse as well, so I'd had that aspect of knowledge of what nursing did. I didn't thing hugely of it but it was just something to do and get paid and get the training.

Something to do to get paid?

To get paid and be trained and get qualifications.

And so really your decision to be a nurse was just not exactly spur of the moment, but it was sort of a ... of looking at the options and saying...

And chatting to this girl who was a nurse, she was in her first year and finding out that with nursing you did get paid, you had tutors and you had goals and achievements set along and you had to achieve them to keep going, but, and at the age of 18 I decided that I needed a structured approach to education, interestingly enough.

Yes.

So I trained at University College Hospital in London.

Oh no that's fine, no, no. You trained as a nurse at UCH, why did you choose that training school?

I wanted a London school because I wanted a nursing school that would be renowned professionally and my parents lived in London and so.

And you had A'Levels ....

I had A'Levels yes. So it was a choice between St Thomas's, Middlesex and UCH. They offered me interviews. My Grandad was a Governor at the time, which was one trigger to the London one, but UCH turned up with the first offer and the first vacancy so I took that one.

Right. Good. And why, presumably you did, I presume you did adult?

Yes, registered nurse.

Why did you do that, I mean rather than children's ...?

I think I just looked at the nurses general nursing and that was it.

These were the only option ....

Yes it was. Well, yes, my older sister is in fact a nurse and a midwife and she is a registered children's' nurse, so I hadn't particularly wanted to go down the children's route. And it was a longer training actually in those days, it was 4 years and I wanted to get on with it. Sort of keep moving.

Interesting how one makes these decisions.

It is.

How did you feel about your training?

I felt that the theoretical side was easy and in some ways what I then ... I did science as a A'Level, and so what I had already learnt was probably more advanced than what I was learning as a nurse, physiology wise, yet the clinical side was a bit mundane, it was interesting, but that was probably the harder bit, actually putting it all into practice, but again, it was right. My first ward was a female geriatric ward and I, I was absolutely aghast that a human being got to that state at some point in their life, I hadn't even gone past thinking about people, getting to be elderly and frail and incapacitated.

So it was a shock.

It was huge shock at the age of 19, absolutely soul distressing. I think even though I had seen an awful lot of trauma and human suffering in India, to see white people in that state was quite a shock.

Yes.

And also I found that I questioned too much when I was training as a nurse and I didn't realise that until I was assessed that the sister in fact didn't like that and put me down, strongly put me down for questioning everything and I should just get on and do as I was told.

So you were actually put down in your assessment the questioning and yes, right.

Wanting to know more than 'just do it'. And that was a huge shock because I hadn't had any pre warnings that that was coming, so I scraped through the first assessment in practice and sailed through in theory. And it was a bit disappointing because some of the group were able to do a two and a half year training and those that they felt could actually cope with it and I wasn't chosen and I think a lot of it, I felt at the time it was because I questioned too much in practice and I wasn't a 'good little nurse'.

Not compliant.

Not compliant, yes. And interestingly two of my close friends that I had become friends with were chosen to do it and that they struggled with the theory side and it didn't seem to match some how and seemed that to be a good nurse you just had to do it rather than questioning why you were doing it. What's interesting is both of them now have moved away from nursing and I've moved on with it completely.

How, what do you think it gave you over and above the overall qualification, if anything?

Understanding about people, it was incredibly formative still because at the age of 19 - 22 its, you feel like an adult, but actually looking back you realise how little you knew about people, so on that aspect it was probably beginning to understand people. Also, it taught me to shut-up a lot more and not to question things, impulsively to question things after a thought, does that make sense?

Yes, absolutely.

There were some wards that I really developed and on those wards felt part of a team, worth it and they were good, other wards felt very much that sisters just want you to be quiet and do the job and not to question, so it was very marked in different wards. I eventually ended up staffing on an oncology unit which I enjoyed in aspects, so being able to care for people, like to crisis point, ... crisis point is something I found I could do and that again deep understanding I suppose of people really and it was so very formative in those days with haematology, oncology and things, its UCH becoming a big centre ...I think also the practice and getting to know how people tick, say one thing and perhaps mean another, who knows formative things. I think also the moving away from home had never been a problem I think probably because I had been at boarding school and whether that independence was too much sometimes within nursing and the fact that I could just get on and do isn't necessarily what's always wanted and maybe it doesn't look like a team worker because you had to learn to be independent and maybe I think it could be challenging for some staff.

Yes, very interesting. So I mean you answered the next question, do you think you developed personally as well as professionally during your nurse training?

I think so yes, yes. And I met my husband, oh a week after I finished taking my finals which was just as well because I passed and got engaged six weeks later, so that was very prompt.

And he wasn't a nurse?

No he wasn't no, not at all. He worked as a bus driver in London.
He is now a nurse yes. So on that aspect it was good, that was very sudden to meet somebody and end up getting married within the year. The next career move really, do without the hospital structure and shift patterns and total flexibility to, because my husband was doing the same, the shift patterns so I moved away to work in a community, initially as a clinic nurse, so and it was a case of walking into a health centre, make an enquiry, being told there were currently jobs and would I like one, so I said yes, so that was that interview system, I've never had anything more formal at all, so notice given and moved on out. And I think about a month after I did clinic nursing a school nursing position became vacant as the school nurse was leaving, so I moved into that aspect. So it was sort of osmosis really.

Did you do any further training or preparation as a result of doing these different jobs?

With school nursing I did, I did the school nursing certificate course which was three months long in 1981, so I'm a recorded, got recorded entries for all of them, that was all and then in 1982 I left to be full-time at home.

And that was a family?

Yes. But with school nursing that was very interesting and I really enjoyed community training, community nursing in a very different aspect to hospital nursing and in some ways I realised I wasn't a sick persons nurse, I was a healthy persons nurse and really enjoyed that aspect of the work health screening, child protection issues all aspects. So within the school nursing there were lots of study day, further progression yes. So that was very much an eye opener in actually seeing people in a city area living at home and

understanding practicalities of poverty and equalities of health rather than in a hospital when you just see them come in as patients and the home situation is an unknown entity. So I think what I know, that broadened me up as a whole nurse to be able to understanding the whole aspect.

So how long did you work as a nurse in a school?

As a clinic nurse for about 4 weeks, school nurse probably 2 years, just under the 2 years, then at that time.

Right and you felt that broadened you?

Yes, hugely.

Yes, on sort of environmental issues, home issues, yes.

Child health issues?

Hugely.

Right. Any, so you did the school nurse certificate, right, any other formal qualifications.

Not then no. When I came back in after having the children

When was that?

1988, December 1988, I started working as a nurse in a residential home, nursing home just weekends, Saturdays and Sundays just to get back in to nursing. To keep up my UKCC registration and so I was wanting to get back into the work force so I did it that way and I got in before needing to do return to nursing or whatever, so that was for a short while but then Alan was made redundant from the job he was in so I, with the same nursing home, I worked 5 days a week, 30 hours a week, so they upped my hours in that and Alan retrained to apply for the DC test for nursing and got in, so that's when he was at home and I was working, he was doing that then. And then while I was doing the nursing home work I also ran a nursery with a colleague who was a school teacher, so we used to do that in the mornings and then this in the afternoons and evenings and we had a visit from a dental therapist came to check on the children and so I was chatting with her and discussing community health centres and I phoned them up and said I am a trained school nurse are there any openings, this is in July 1989 and they said yes, there are two vacancies, apply and we will see where we go, so I did and I got a post again as a School nurse in Herne Bay to start September 1989.

So you had moved out of London?

Yes, we moved out of London in 1985, beginning of 1986.

Right.

So I got that school nursing post in September 1989 in Herne Bay and that was again very very good and moved me back into health nursing again, really. Working in the nursing home was very good for basic nursing skills but it wasn't really what I wanted to stay in, it

was a stop gap and so moved in to school nursing and I was there until February 1991, so again not a huge length of time but got going again, just did what was needed, started counselling drop in sessions in schools, did teaching on health education and sex education with a health visitor at Secondary school and primary school so got a lot going in the short time I was there, as well as all the routine things and then sat back and thought I would like to do this for ever until retirement? and decided no, with the way that things were actually changing in schools at the time I thought I need to broaden out, so rang up the local hospital in Thanet and asked about vacancies there and had an informal interview with the head of nursing and then applied for a surgical post in one of the surgical, female surgery which I got, which was a huge drop, from a G grade to an D grade, because I was moving direction, interestingly I had an increase in salary because doing night duty, unsocial hours, weekends, that upped the money.

You were on part-time as a school nurse were you?

I was pro-rate 80% yes. So financially wise it wasn't a problem, but moving from a sister to a D grade is very interesting because you are not meant to know anything as a D grade and again I think perhaps because of what they've been doing, there was a new curriculum so that's interesting, but again it teaches you to treat people as people, rather than what they are meant to be doing and so its useful. But that was excellent experience to do and I did that for 6 months in the end, so surgical nursing, moving back into ill health, but coming in with it with a huge wealth and experience, life experience, nurse experience, health experience, all those aspects and that was in 1991. My husband started the nursing programme in September 1990 and came back in May 1991 saying do the diploma in Midwifery, get yourself on it, because you need more training, more qualifications, this is the way to do it, so I applied for midwifery purely to get diploma which is interesting.

So that was about August 1991?

It was. And I had thought about doing midwifery years ago when I did school nursing, it was a toss-up, midwifery or school nursing and I'd opted for the school nursing, so it was like reactivating something donkey's-years previously, so I felt good starting midwifery. My Mum was a midwife, my sister was a midwife as well, so but took to midwifery, it was excellent and its a very good mixture of health nursing which is a bonus. But using your nursing clinical skills for women, families who are not ill but are also the fact that I had done recent surgical experience was incredibly supportive for the women who did become ill. So it was excellent on that side. And the fact that I was a community trained nurse was very useful for doing the community aspect of midwifery, and so that wasn't a new entity for me at all, everything I had done, had made midwifery better.

Sort of lead into or, yes, yes. So you would have taken 18 months to qualify as a midwife, so that would have been?

February, um March, beginning of March 1993. And I remember how I enjoyed it, it was very stretching actually starting to write essays again, academic essays and doing, and amazingly enough I was pleased I did quite well in those. I don't know how I managed it actually, but there you go. Because it was so different to having 12 years previously or 10 years previously doing the school nursing certificate, a completely different ball game. And got through that all right, the practice was OK, I really enjoyed being a midwife, it was hugely demanding, very stressful and being responsible and having two peoples lives in

your hands etc. but it was, I think an aspect of my professional career as such that I had autonomy and I could question and I could decide and make decisions and challenge doctors so I was moving into the autonomy that I probably wanted when I was a student nurse and wasn't going to be given, and so it brought it all to the point and I think as much of that is the fact that it was new style of education, higher Ed, critical thinker and everything so.
No, and it was a relief to actually be able to question and to be given answers, rather than to be told you don't need to know that. So that was, it was almost like arriving home in a sort of way. And then 9 months after I qualified as a midwife we moved to Australia.

Right.

So you'd been a midwife

So that's December 1993.

That was December 1993?

Yes.

So you a newly qualified midwife and Alan a newly qualified nurse?

Yes, 13 months, yes.

So we upped and offed.

So you'd got 9 months of midwifery experience

And I'd made sure I'd got high risk ante-natal and post-natal experience and labour suite experience before I went as you needed that, to make sure I felt an all round person. And got to Australia and got a job, I think within 2 weeks of being there which I started on New Years day as a flexi-midwife at a little local hospital which was excellent experience. We did 30 deliveries a month, there was a surgical unit and day surgical unit as well, so there were nurses around and doctors around in the day, but not for the midwifery side, so huge clinical field and my midwifery training in England actually was excellent and I don't actually think they ever realised I was so newly qualified because I'd got children, I was older and I was from England, so in some ways this is where my independence comes through, so I can.

With the knowledge base as well.

And just to do it, and that was very, very good experience to have to depend on your midwifery knowledge and skills of the normal, the deviations from the normal, so very, very good consolidation. And then after I had been there 8 months I got a permanent post in Melbourne as a midwife and it was to work on the labour suite there which had about over 5,000 deliveries, so it was called a regional Centre and they had transfers in from inter-state and across state, flown in from all over the place, so very high risk experience and totally consolidated midwifery training and gave me more than I would have ever achieved in this country because again, even though there are doctors on site, there were so many women who had private obstetricians and the doctors, they are not on site and you had to call them in as needs be, so developing midwifery knowledge to inform

obstetricians on the phone what the women are doing, again, hugely beneficial to being a midwife and to be able to read situations, understand and to act and sometimes without the doctors there you still have to act. So very interesting to see another medical system, healthcare system.

So you were there for how long?

Nearly 2 years and I worked on the delivery suite all the time and also at times covered the family birthing centre in the hospital which was a midwifery led unit with ultimate consultant cover but there were no doctors actually walking around, doing the rounds, it was completely midwifery led and any deviations you had to assess the whole situation so that was very, very good experience again, to do the total normal, like home from home, home delivery to care with no machinery unless you really, really needed, so I got a bit of experience there and then we came back to this country in August 1995 and picked up again at Thanet Hospital as a midwife and worked with their teams, midwifery teams, parentcraft all sorts of things and progressed to an F grade and then felt I had got together my, well at the time I was happy with my clinical but I needed something more, went and took the degree which I completed in August 1997.

So that was a degree in midwifery?

Degree in midwifery yes.

Post-reg?

Yes, post-reg and at various points throughout my career people have often said to me, why don't you go into teaching or go back to school nursing, second time round, 1991, 1989, 1990 I took students out with me as such and I enjoyed that very much being able to pass on information to allow students to question and challenge I found that very stimulating, and, I do want to do it in nursing and then moving into midwifery and thought well maybe midwifery and being in Australia people were saying why don't you move to teaching so when I came back here, I thought I got midwifery, you know I'm doing clinical midwifery, I've got my degree, I need the next thing and I found out about teaching here and after about a year the post for midwifery LP came up which I didn't go for initially because I was just finishing my degree but it wasn't filled so I phoned up again and asked for a little bit of information, whether it was going, and they said yes, so I applied and got the post in July 1997 and started in September 1997.

Right. OK. That's great. I want to just backtrack a little bit because I want to ask you, if you're, what do you feel is important about, in nursing/midwifery and what sort of a nurse, what sort of a midwife would you describe yourself as?

Right, I think being interested in people, for me is an essential aspect of wanting to be a midwife, wanting to be a nurse, I feel you need to understand people in whatever context they're in and as such allowing them to talk to me about themselves so that I can understand them, having that ability. I think those aspects make me a good midwife as well, also being knowledgeable about my role and being able to give the information to people as they need it to understand what's happening as well. I think also not being worried if people observe me and not to feel threatened by it, because its when other people learn, that's obviously a bit of a pressurising situation because you've then got to be competent in what you're doing so you don't mind if they observe and question.

Do you think it's different, your sort of views of what's important in nursing and in midwifery or do you think that they are basically the same.

I think they're probably basically the same, except as a midwife I feel, I think as a midwife and perhaps as a school nurse I had more autonomy and so I was able to, I am able to make decisions and to push things to the conclusion, where as a nurse, and it may be because I was only a D grade nurse, that wasn't my role, so yes that was different and that was frustrating as a D grade nurse, its also frustrating as a hospital midwife, as an F grade because I wasn't a G grade as such.

So you weren't actually in charge or?

At times, yes I would be in charge, but ultimately I wouldn't be in a position to suggest changes and why and that's frustrating. You asked me something else?

What sort of nurse/midwife would you describe yourself as?

Good midwife

What do you feel about, you know, what's your philosophy.

Oh, to women centred, family centred and to support them in a situation that's often incredibly frightening and unknown and to make them, the mothers, the families feel safe so they can actually fulfil having a child, whatever that might mean for them. So being a person that people feel safe with. Competent actually, that includes being competent and truthful, if you don't know something, find out, say to them and find out, and keeping promises, if you say you're going to do something, do it.

Right, its more important if you say you're not going to do something, don't.

Yes, I agree with that and if you can't commit yourself, say I can't.

Yes.

Keeping up to date, keeping my knowledge base on the sharp edge, which is time consuming ...

So yes, anything else about how you would describe yourself as a nurse/midwife?

No. I don't think so.

I think you've sort of said, what or who influenced you to take up the role of lecturer/practitioner, it was something that?

It was other practitioners, yes, encouraging me to move on into, why don't you teach and I've always enjoyed having students and teaching them, medical students or whatever and you know your knowledge base correct at the beginning so moving into teaching I thought well let's see how it goes, I know its not always easy if you're in practice to balance.

So it was sort of something that just sort of evolved really.

Great thanks very much, that's really all I wanted to ask you at the moment. Is there anything you want to add, anything you feel I haven't asked you about.

I don't think so, no.

Right, Ok, that's a lot.

This is the second interview with Amy. OK , thank you very much Amy for taking the time to be interviewed for this research. This interview will also take about 45 mins and it's going to explore with you issues in relation to you as a lecturer within the role of lecturer/practitioner. Its also in three parts, firstly I would like to ask you about how your knowledge and skills as a lecturer/practitioner have developed, then I would like to go on to ask you about your values, principles and purposes as a lecturer/practitioner and finally I would like to ask you questions which will explore your perceptions of the role. OK. So a biggie to start with, I would like you to just sort of tell me what you do now on a daily basis. You know, briefly talk me through a typical session with some students and why you do it like that.

Well my sessions with students are mainly teaching sessions, so they are constructed around the BSc midwifery programme, curriculum and are as such are very structured, but within that structure I aim to teach the theoretical components that are necessary but very much building it around how it will be applied in practice and on that aspect I very much plan the teaching to fit, make it as practical as possible, so that it can be put into practice. The ability to do that as such is I feel very much linked to the fact that I have only recently come, well a few years now, out of a clinical practice situation, purely and over the last three years I have also still been maintaining clinical practice one day or so a week which has kept me up to date with how things can be applied in practice and do you want me to talk about how I am now?

Yes, well I mean, you are now, are you actually still doing practice?

Yes.

And this year I have started with just 110 clinical practice hours in a year, so I can still work as a midwife actually on a maternity unit to keep my school current within midwifery and I choose to use that purely for myself, I am not there to work with students in any mentorship aspect or structured aspect so I purely go to work as a midwife and do whatever needs doing as a midwife within the day to day running of the ward. Ultimately when I'm there people will ask me questions, management issues, teaching issues, all sorts of issue, but I very much direct them on really to the midwife in charge, discuss things through, but then direct them on to whoever is in charge, so that I am not seeing to be taking away from the midwifery staff there. And also anything to do with link aspect I refer them on to the current link lecturer in the clinical areas that I am not actually there in a link capacity.

Do you, is that your clinical link area?

No.

Its a different area?

Yes. And that in fact I think for me is better than linking and practising in the same area because that very much blows the whole issues. So I see actually working in clinical practice for me essential to knowing what is still happening in the clinical area, especially related to staff shortages, how busy you are in the work area, the demands of clients, how that really impacts on the care that we can give to everybody, for a person who needs a lot of attention that are, and also current practice and how it's being challenged and changed, the new guidelines brought in, thetas very essential to know, so I can actually bring that into the classroom teaching.

Right, right, I want to bring you back a bit, to the classroom teaching, because I want you to think about, you know, you as you are now in this sort of, you know, talk me through what you would do with the students. You know, you start off with the session, what sort of thing, a typical session, I mean have you been teaching this morning?

No.

Last week. What did you do?

Well, with midwifery students it was previous, was it last week? Yes, did concepts of risk, these are post-reg students and it was looking at interpretation of well, use of cardio-tocographs in practice and the importance of it and so within that session presented why we use fetal monitoring, just some of the pathways within the anatomy and physiology.

So how are you doing that? Are you actually doing a recap

With acetates

With acetates, the physiology?

Yes. So that it directly relates to the actual practical application of what the CTG is picking up, why we are monitoring the baby, bringing those issues back, relating it to Royal College of Obstetricians, Gynaecologists and their guidelines for practice and just relating it to clinical area guidelines, use of documentation those aspects so that links into the UKCC rules.

So how would you manage a session, you would use acetates, how many students would you have in that session?

Well there are only 4 in that session, there should have been 8. I do it very much on an interactive basis and use the acetates so that they can think about it and then apply it to practice and I draw them out that way. So you can talk about what they actually do in practice and then relate it back to guidelines from people like the RCOG and midwifes rules, so they can see the reality of what they are doing in practice backed with the theory component of why it should be done. With this session I actually wanted the students to write down what the, what was on the acetates and think about it and make it discursive, so I did that with them in the session.

Right. Why do you do it that way?

For this session I did it that way so that they actually had to go a bit slower with listening to what I said, reading what's on the acetate and then writing it down and it also makes me go a bit slower so that I am not necessarily giving lots and lots of information. If for a session I need to give

Why?

Why? Because its more of a complex issue and I wanted them to really understand it so that they could really apply it in practice and really question why they do it in practice as they do it in practice. If I'm giving a lot of information out and I want a very interactive session, very often I will give students copies of what's on my acetates so that they don't have to write, I often find that if they do that they write all the time, they don't hear what I'm saying and it doesn't actually support their learning, but on this time I took it a bit slower so that they could write and think about what they were writing and it seemed to work I think.

Right, good.

And the questions coming back from them about the information suggests that they were thinking, 'aah now I know why we do it' as such. And then with that session moved them on to thinking a little more behind why obstetricians ask for specific aspects of management in labour of midwives, so that the midwives can actually think about why they are being asked to do things rather than just a case of 'yes, OK I'll do it', that they have the knowledge base behind why its being done and thinking of them as students, they're already experienced midwives doing further education so taking them on, hopefully to a higher level of challenging practice and being able to understand the actual obstetric management in high risk situation.

Fine good. So you do it, you've talked to me certainly about 2 different strategies you would adopt within teaching, at least 2, because you talked about other things as well. How did you get to that point?

What within myself?

In your own teaching in your own approach.

I think a lot of it started going back to when I was a midwifery students and observing tutors practice and I know for myself I like questioning things on an ongoing basis, and so to have somebody teach me interactive I found useful as a progressive step within the teaching component, so I that what works for me and I'm also doing my Cert Ed, teaching in adult learning theories, the different teaching and learning styles of students. So picking up on those aspects which is one reason why I do that. I'm also aware that some students don't like the interactive style and would prefer not to join in and yet teaching in this was I feel I need students to interact to a certain level so that they can carry on doing that in a clinical area. So I probably do tend to try and draw the students out to help challenge them in their learning style to help them to move on to be critical thinkers.

So you draw you students out to enable them to challenge you?

Yes, yes. I'll introduce sessions by saying I like an interactive style and I don't mind being interrupted, that in itself for me has been challenging because I know when I started teaching it was so much easier to have it written down and talk it out and think if anybody asks a question that will throw me, so bring it in tight but I've developed myself to allow for the interactive session and as I've done more teaching I've got more confidence in listening to other aspects but then drawing the students back to the thread that we're following.

Right, that's interesting because you know, one of the questions that I was going to sort of get on to is, you know, tell me how you think your practice has changed as a lecturer?

Yes I can. Yes, I mean hugely challenging to begin with, very prescriptive style, even so I would still allow the interaction.

Why do you think you were tight and prescriptive?

Because I was concerned that I'd be asked something that I didn't know the answer at that point and it felt like I'd be caught out so to counteract that, even though I was very prescriptive in what I wrote, I also did a huge amount of reading around the subject and I'd have lots of notes and things everywhere just so that if somebody asked me something I'd think, yes I've read that. But I've learnt to relax on that a bit more and say actually I haven't followed that one through, but I'll come back to you on it, and then to try and remember to do that, so I needed to relax on that a lot more.

And that's come with confidence?

It has yes. And confidence alone, that actually I do know the subject, probably better than I realise it, or thought I did which was good. But thinking back to before I was lecturer as such, doing parent education classes, before I did my school nursing with school education things, I would then even draw on a much more interactive style and because I wanted to know what people wanted to know, rather than just give them the information. So I've bent towards that anyway, really.

That's a natural .

I think we, yes the Cert Ed that I did, highlighted, I mean I knew it before but really highlighted the fact that the different learning styles you are going to have quiet people in the group who will not talk and will not offer an opinion in a big group, but, put them in smaller groups they may well come out and discuss things, so I very much will use interactive small group work and then a few back into the bigger group and going back to the CTG workshop as such, I did put them into groups doing actual CTG tracings of the foetal heart-rate so that they could work more individually, I know in a group of 4 that's a small group anyway, but that's, I've used that technique before with the same session.

So where have you got the CTG's traces from?

From actual cases, kept in confidence, the names off etc. So again, my links with clinical practice have been able to support teaching material and things, but also there are very good books with CTG's in and things you can use.

So how do you think you've changed, not, feel like now, compared with what it felt like then?

Much more relaxed, I think confidence in me has grown in that I can teach, which helps, and that people seem to understand, and I think that I can, even if I'm perhaps thrown off tack I can bring it back in without panicking about it.

Right.

And I think confidence in the fact that I do know what I am talking about, if that makes sense. I don't put everything down on acetates now that I want students to learn

Again because what you do now you didn't do then.

Yes, I have more bullet point on an acetate and talk around the subject a lot more. Which I realise also from giving them out as handouts that's not so easy because students then have got to write some things, so from that aspects I will often give out the acetates, like so many at a time and handouts they can make notes around.

So they've almost got like an incomplete handout really that they have to

Yes, yes, they can't read the end and then switch off, but I'll throw it in during the session, those aspects to try and keep them awake and not switch off. But I don't find it actually throws me personally if I notice a student has dozed off somewhere and or that they are just not listening, but I'll often, if we then do a bit of interactive work I'll go to them and find out if they're actually OK, more of a pastoral aspect really.

Yes, so you were saying that the group you were talking about, the CTG workshop with just the 4 in, for other groups, what would be the sort of normal numbers that you would have?

It can be 12 - 15, maybe 24 in a group. Yes.

So would you have to adapt how you approach things?

Yes, if its a bigger group the interactive style can get a bit loud at times and I usually, I manage to bring them back - and tricks from Cert Ed, whatever.

What sort of things?

One thing to try and get their attention and then to, if they're all talking, just stop and then just wait for them all, then they suddenly realise that you're waiting to say something, or I'll just say, hang on a minute, lets just listen to one another and one person speaking and if two people try, you just say hang on a minute do that and try and go back, so the actual group control I feel much more comfortable in. I feel more comfortable in it now, I didn't feel that I really had a problem with it to begin with, which was very comforting because that was a huge concern that I would have problems, that students wouldn't listen, etc, but that hasn't seemed to be a problem.

Why did you think that might happen?

I think really, because after being a student in a group where they've been hecklers and seeing the tutors not control it and then disintegration, hecklers carry on and then you think, 'that's a waste of a session', so I've seen that side of it and I thought, I don't want that to happen to me. So to counteract that I'd try and make what I'm doing, I think, practically applicable so that it is necessary for them to listen, but its a difficult thing to be so much akin to them, but still to be their lecturer, giving them the new information and that balance is probably developing to be more, not a problem, but I'm aware of that.

So, sort of boundaries of you as a lecturer, you said, you almost feel akin to them, what do you mean by that?

I think, probably when I started in lecturing, I had been working as a midwife and they were student midwives a lot of them alongside me, so I was a midwife and then suddenly I'm a lecturer, but I'm also in clinical practice so I'm still practising as a midwife and so as that, yes I am moved into a new role, but I'm also a midwife the same as them and yet here I've got a role of teaching as such. And trying to make it that I'm not a lecturer and then a midwife or whatever, I'm the same person all through, balancing that aspect and I think it gets more tricky now with being a personal tutor to my students with having a cohort with myself and another lecturer and there are issues that you have to deal with, management issues and shift patterns and what they're actually doing and yet to still be the person that they feel they can come and talk to and download to and ask for support from, yet knowing that I also have a role in saying 'that's not right, you can't be doing that', so it's balancing that aspect, and knowing full well that some students must say 'stuff it, I'm not going to bother because I don't like the way you've had to tell me so and so', so that's a difficult one, that there are issues that we just have to stick them in because its curriculum, College boundaries etc. and Trust things, so its balancing that and trying to stay approachable enough that they can talk, but knowing still there are boundaries they have to abide by.

Yes. In relation to how you've changed, what sort of knowledge do you think you've got now about being a lecturer that you didn't have then?

Crowd control teaching styles and then the ability to actually teach for 2 hours, I still think, gosh that's not enough time, whereas before to put something together for 10 mins was hugely daunting and being able to relax in filling 2 hours, maybe 4 hours teaching and to keep that going, so that students don't switch off and be aware that they might be switching off, but then suddenly they will come back.

So what sort of knowledge, I mean what would you use if you are taking a 4 hour session, it's a long time, how would you manage that?

Different teaching strategies, acetate work as such, then some group work where they get into groups to put together what they already know themselves and to apply it to the new theory, maybe videos and students feeding back to the rest of the groups that they're actually doing something within the session.

And do you feel that is, what does that change your strategy, what's that based on, what knowledge have you got?

It's from the teaching certificate, PGCE a lot of that, the adult learning theories, those aspects. I think the Cert Ed was very hugely instrumental in being able to do the teaching,

I think that's obviously what that helped. Just also increased knowledge base, being able to, the facilities at the College have internet, library, books and the time, you have to make the time to research information so that it can be presented in an applicable style, not just as knowledge but just as applicable knowledge, I've developed a lot in that and my resource base is so much better and then.

What do you mean by your resource base?

Teaching materials, lesson plans all those sorts of things and just the more practice I've had in doing it the easier it is to do it, so experience in doing the job has helped. I think also doing the Masters that I'm doing with the extra input, taught input that I'm getting and things.

What's your Masters in?

Health Education and Health Promotion.

How far into that are you now?

I'm in the second year now.

So another year to go.

Yes, its the three years altogether. So that aspect as such is very very good information that can support and broaden what I am teaching in midwifery so that's hugely useful and as such I use it that way. So, just reading and also the interaction with other midwifery lecturers, that again is very helpful in knowledge base and I think also being able to go into the practice area as a link lecturer but also as a midwife that is very beneficial to my knowledge base that I can bring it all into the practice area. So that's changed.

So, really in the light of what you said about your understanding of strategies, adult learning theories, things you've learnt on you Cert Ed, how would you present to students or, you've actually already talked it through in lots of ways, its possibly a question that doesn't need to be asked, but again perhaps thinking about a session you might do with the BSc students, how would you, how would you manage a session like that, you know now, thinking about what you did when you first started?

I very much, I think more so nowadays work with what they already know.

Even those right at the beginning of the course.

Pre-registration. Very much on what they've already known, but within this, within the new midwives, I do, I think throughout it, the hugely challenging aspect of being a midwife, I thread that through most sessions and to help.

What would that be, how would you epitomise that?

Well, talking about any issue, just in labour, if they're already mothers themselves or they've got members of the family with children, I relate it to what they felt, what they've already felt themselves, so that they can think about what they would like in a situation, but to take it further to challenge them about what happened to them doesn't necessarily

repeat with everybody, we all have different experiences, so even for them to recognise they've got experiences that they have to be open to other peoples, really to stop them hopefully stop them thinking about me all the time and what I would like in the situation but to think about the mother, what the father, what the family need so and I aim to challenge them within that so that they can become broader people and support women in any situation. But a lot of midwives, students midwives at the beginning get very challenged and get stuck with what they were experiencing in labour and pregnancy, childbirth for themselves or family members and don't seem to move beyond it, to be able to care for other people and so I sort of build that in quite a lot, all the way through and often, the support afterwards and just ... if there really is too much to say at the session, OK you may find it too much, you need to know it but at this precise moment lets talk about it another time and sometimes, they haven't as such opted out, but.

What about if you've got the very beginning of the midwifery programme, you've got somebody sort off hot off Project 2000 sort of age 21, not very much life experience what, would that present a problem to you?

It's a problem, it has to be dealt with and addressed because they can come straight into midwifery there's no rule to say that they can't, that is a problem in itself because they don't actually have nursing practice experience either, so their life experience may be minimal, their nursing experience is minimal and as 18 month midwifery students, they are expected to know how to manage a ward usually, how to interact with doctors, with families, with other members of staff and in a way that's very hard on some students so try and build in that knowledge and expertise for them, but knowing that others may have actually got years of experience and try to draw them in, utilising their experience but allowing, you can do it as such, because they're all new to midwifery, so their interaction as midwifery students to doctors is different than nursing to doctors, so it can be taught, hopefully without making people feel that they don't know much or stuck because they do know quite a bit, it's like teaching grandma to suck eggs. But its a huge, a delicate balance with such huge ranges of experience and.

And how would you manage that in a group?

In a group? Allow them to talk and come out with experiences and very often if the midwife student says 'oh so and so, I spoke to a doctor and this a, b, c happened' and I'm thinking that's because you are very green in a situation you didn't quite know how to act, but I let them throw it open to the others and say 'what do you all feel about it?' 'are there any other areas of practise, clinical areas that do things slightly differently or how can you relate it to our accountability', so I would draw on other people experience, so that it is like peer information.

Yes.

Rather than just me doing it. So utilise the needs from other people, experience from other people and do it that way.

Great, thank you, that's very useful, very helpful. I now want to move on to this next bit. How would you answer the following question? My view of the purpose of what I am doing in nursing/midwifery education is...

Prepare practitioners for their role as midwives, so in the speciality that they have chosen

and to do that they need a broad knowledge base of the area of practice that they're getting their registration in so that they can safely practice and also to build into them the ability to, for the student to develop their own knowledge base so that they can you know do further study, the life-long learning aspect. I look at myself as a resource of the information, but not just a resource for information but where they, to direct them on so that they can find it out for themselves and it depends on the level of the student as to whether I give them a lot of direction or throw it open to them so they can use it as a jumping off point and go off. On that aspect, I mean talking about midwifery its a totally new area, so yes, I would have to give them the information but that wouldn't be fair if I gave it all to them without helping them to develop as people to go off and find out for themselves. And I think in midwifery it is very much the ethos of working in partnership with women so that, as a student, or as a midwife they work alongside women and they have to give information to women and support women so that they know where to find out. So I do it very much like that, if I'm the sort of midwife teacher that can work alongside students work in partnership with them, hopefully that will help them work in partnership with women, so its not on a.

Sort of role model really.

Yes, and not so much on a hierarchy as I'm the lecturer, you're the student, but Ok, we're all midwives, yes I'm a lecturer and I'm giving you information, but I also value what you've got and do it very much more on an equality basis, very humanistic really. So that aspect, and I think valuing students as coming with what they know themselves and that it's valuable for them, it's their experience, to building up from that.

Well one of the things, you know, what do you think that midwifery education is aiming to do? And how do you see you role in it?

I think I've said, haven't I.

And do you think that you have a distinctive role in midwifery education? What is it you give students that other lecturers don't/can't give? I know that's difficult to answer, but you know, you can be as objective.

I did my PGCE study on the role of the midwifery LP.

Really.

it was a survey and students answered to the point of what do I, what does the midwifery LP give in lectures that is different to, so I've got this information and really the things they brought was the actual immediate application of what's happening in clinical practice to the lectures, the fact that they saw me in the clinical area practising as a midwife was different to how they saw the other lecturers, who visit in clinical areas, but not practising. Other things like, I used relevant scenarios that were up to date to relate theory to.

So how did you do this, you actually had a survey asking various cohorts of students?

Yes, any one time, we did have three cohorts, the junior group, the middle group and the senior group and so I took those three groups and out of those three groups I was working closely in the clinical area with the students in the link area, so they would actually see me practising as a midwife, so I took them out of the three groups and they were the fourth

group because I felt that they might actually be saying things like, my clinical experience and that they see me more as a practitioner midwife than a lecturer and I wanted to find out whether that was true or not, it did highlight that, the midwife students that didn't see me in the clinical area only in class there wasn't such a huge distinction between what I did in College, the fact that I practised in comparison to the lecturers but the ones that saw me actually in the clinical area did look at me more as a colleague and that seemed to come through and have, the responses had they replied to them.

Right.

So it was interesting looking at that.

Very.

So what was also interesting in that survey, the student midwives did all feel that the current lecturers in midwifery were clinically up to date as well and midwifery lecturers do have to do clinical practise every year as well. So that's how student viewed me, I mean midwives I know in the clinical area, I get this all the time, oh its nice to have somebody who is actually practising and huge anecdotal comments from that is incredible and how its almost like they feel, great, somebody who knows what's happening in practise is teaching it. I also meet that with teaching on the post-reg because I'm teaching midwives that I was a colleague, and that is hugely daunting, suddenly I'm there teaching them and they're perhaps more experienced in years as a midwife than I was, but I've done more academically and taken it further and that's interesting.

Right.

Because I think that certainly is pivotal on being a lecturer/practitioner and the, I feel to have a foot in both camps and to still do work in practise and in education, but for me being in practise I do not want to be a manager in the practise area and be like a half and half in the clinical area, because to be able to go into a clinical area for my own benefit, professional development, for my teaching aspect such, is selfish, it's purely for me and I'm not there at the beck and call of the managers to say, you are going to work a night shift, or a late shift, or actually no its an early, we need you on call, and then be juggling all of that and try to juggle education and things, that would be, I couldn't cope with that and I think the demands of midwifery practise are meant to be so flexible nowadays that you have to be the jack of all trades and the master of all trades and to do that style of work and to be a midwifery lecturer would be I think defeatist. So to have the safety net of being employed by the College and able to practise, is I find, very good, because I can still inform on management issues, be a resource in the clinical area that I'm not there to perhaps do the off-duty or do a, b, c and d that have to be done as well and have to stay overtime because there's nobody else and to work an extra shift because there's nobody else and those aspects that would be too much, I think especially nowadays with staff shortages, demands of clients.

Where do you do your actual clinical? Because you link in?

Maidstone, my linking is Maidstone.

But your actual practice?

Is in Thanet.

Is in Thanet, right, so that's interesting because they know you at Thanet, I was wondering whether, I mean if it was the other way round, how happy you would be in Maidstone, the management to sort of let you practice, look after a woman.

I think they would be fine in Maidstone, that hasn't arisen

But do you know what I mean, its sort of how much, you know, you're an unknown quantity to them in a sense.

Yes, I had that at Medway, because when I first came here I as practising at Medway and they didn't know me from Adam and I did have an interview with the manager and she basically said to me, well we don't know you from Adam how do I know you are safe to work with patients and clients, you've really got to prove yourself first as a midwife before I can say you can have an honorary contract to practise here. Everybody else that comes to work here has an interview, just because you're at the College doesn't, an interview for that doesn't mean that I feel that you are OK to be a midwife here. So yes, that was a huge shock seeing as I had just come from practise but I didn't take it that way, I just said yes, I think you're right, and, but that was all right, I did, I put myself through, she wanted me to do rotation round all the areas and I said, that's great because that's what I want to do anyway, I need to know what's happening in the area to be able to practise so I orientated myself that way and then they just let me get on with it and to practise. But yes I had to prove myself and that's hugely daunting, because its not just that you have to be 100% knowledgeable it feels as if you have to 110 - 120% and you are very much being looked at as we know what you are doing, don't you. So that's very daunting and it's daunting in Thanet as well.

I mean in a sense you've sort of, we've gone on to the next question, which is tell me what its like to be a lecturer/practitioner in an academic environment? I mean one of the sort of down sides is that you are going into another area and we cover a huge area in East Kent don't we and West Kent as well and so you have to, that's one of the issues, is there anything else. I mean what's it like being, how do you feel about the role?

Well the actual practitioner, I think I mentioned it earlier, but it hugely demanding to be, if its a half and half job to be able to maintain educational knowledge, everything that goes into that and how curriculum's are planned, the whole structure of education in half a week is incredibly challenging, to do clinical practice and maintain a cutting edge of that in half a week is also clinically hugely challenging and to marry to two is much to arduous basically.

I mean one of the questions I've got here, can you tell me the tensions that arise and how do you deal with them?

If I was a lecturer practitioner and I was seconded to the other half, like if I was a practitioner and seconded to education that's from what I've picked up from other people is hugely arduous and they expect, seem to expect whole weeks work in half a week and think that you're in College to have a doss and its, oh you just go to College and just sit around and teach and that's it, and there doesn't seem to be the understanding of what actually goes into teaching preparation which is hugely demanding and I think also the education doesn't always necessarily always understand the demands of the clinical area

and actually what it is like to be at the grass-roots level where you cannot come off duty because there isn't actually another midwife and yes there's all sorts of health and safety issues and how do you actually deal with that and then put it all together and come and teach the next morning and you're exhausted. I'm able to balance.

Or be on call.

Or to be on call yes, I mean it's ridiculous but they're being asked to do it. Now for me, I can plan which day I do clinical practice and I make sure, hopefully make sure that the next day I'm OK and that I can give my energy for the next day, so I do balance it around what my needs are, whereas if I was in practise I would be balancing, I wouldn't be able to balance my teaching from service area because I would be there at their beck and call to do the duty when it fitted them, but I'd very much want to have control on that and that would be high on my agenda to say, actually I can't do those shift realistically and get the managerial support on that. Otherwise I don't think you can actually do it, so you would have to be quite assertive about what you wanted.

There are implications and the sorts of contract that people have. Yes.

And yes, you may need to be a G grade and half managerial input or an F grade have managerial input, but be able to have time to do your educational input and I don't always think that the clinical area realise how much of an asset somebody is whose got their foot in this camp here in education to take that the clinical area an I don't think its always recognised as a huge aspect and what you could actually do within the clinical area. I don't they've actually got time to think about it at the moment so that like be detracting from it and you're very much just doing the job as it presents itself reactive care, which in midwifery it is, you can be sitting around with nothing to do and the next minute all hell is let loose because of an emergency, its like an A&E department, you have to be ready for anything and just balancing those two demands would be hugely demanding. Personally I wouldn't want to do it and I've been fortunate to negotiate clinical practice for this academic year, whether it carries on with the demands of what's going to come in this institution with the direct entry programme, I'm not sure, but I do want to maintain some type of clinical.

I mean you talked about you know, balancing your needs, do you organise things, your shifts, do you normally come on a 9 - 5 or do you go home early or what?

When I was up at Medway, I did more of a 9 – whenever it was more of a 9 - 3 and was just there, had quick lunch break as such because I balanced the like 2 and a half 3 hours of driving that I might be doing, so that also balancing things so I don't get too exhausted, now I'm practising much nearer to home, I so far have done early shifts 7.30am - 3.30pm but also I am quite happy to say, right at 2pm the next midwife it taking over and go to move on because I usually come home and do more work, so its not like the end of a day, so clinical wise I do that and also I have negotiated to do a late shift to suit round me.

So you would need to be careful about what you do the next day.

Oh yes. And what I've done the day before. If I've done something heavy the day before, then there's an early shift suitable. But also I do tend to look round to see who else is on duty and so make sure that I'm actually perhaps going to be useful so that I, on a busy day, then I actually get more clinical experience than if its a quiet day. But also where I do

the practice, I will dictate that, yes I do dictate that.

In what area?

whether I'm on the labour ward, or down in the post-natal ward or ante-natal ward and also the ante-natal bit, the day assessment unit or whether I go out in the community and that aspect I would probably need to go with a midwife, but so on that aspect I dictate where I am going to go to, but I'm also flexible enough that if I think right they're quiet here, I am able to go and say I'll go and work so and so, otherwise they might just see me as just somebody who just comes to dabble because that's what suits her. So I suppose I am careful to make sure that they feel that I am actually useful.

So you're supernumerary but you're still useful.

Supernumerary but they also short of staff.

Who or what have helped or facilitated you in your development as lecturer? And the other side of that, who's hindered or what has hindered?

I think Sylvia as my buddy when I first started and just being there, very very useful, other lecturers in midwifery have been hugely supportive with resources, knowledge base, again that is also a huge hindrance because they know so much, its incredibly daunting to try and match them and to think wow have I got to be the same as them and students won't listen to me, because they will go to the others who have got more experience, so again its a huge hindrance.

But in fact you found that they do go to you and they do ask you about practice.

Yes, yes. And also hugely hindering was the fact that I was a student for the lecturers, they taught me and so suddenly I'm now trying to be one of them, that in my brain is difficult to get round and I don't know whether it was a hindrance for them, I can't speak for them as such, but for me, to say, no OK I'm me, I can do something, I can be equivalent, all the lecturers together, but still feeling a bit of the new girl on the block sort of thing. But that's changed and now its very humbling when they come to you saying, you've got so and so, can I look at this and I think actually now I'm being used as a resource for them and that's tells me that I am part of the team. I never feel I wasn't but there have been issues that I've thought, I'm not having that and I've challenged it. But learning to speak my mind without being aggressive for me rather than thinking, huh just used to be a student now I'm trying to be a lecturer so listen to me, but daring to do it, that's been very formative for me anyway in character building I think. So who else, Penny's been supportive of my role for what I've needed to learn and opening other things, opening things up to me really and having an overview of what I've done and where I need to still develop, I think that's been useful. And just sounding board at times.

I mean in a sense systems do you feel?

I think the IPR system has been useful, the Certificate of Education, the Buddie system is very good, Head of Midwifery, having an overall look really at what I'm doing and she placed me initially with up at Medway, to train me within the Link role.

Right, anything else in that?

Oh, I should say another system was the professional development study day support within the department was helpful to me, my own development and what the College have provided as well, that was good. And doing my Masters, I mean that's been helpful. So that, well the ethos of professionally developing your staff I find very, very supportive and just the ambiance as well and that, support is there if we need it.

Finally, what are the rewards and satisfactions of the role?

Seeing students come in, green in the subject area of midwifery and becoming midwives and progressing within their first few months towards that, that's very rewarding. Also what's rewarding is when the do well in assessments, and I think, oh that's good because I put a lot of, you know of the formative bit in, so that's silent feedback for me. I think job satisfaction, that's rewarding.

How would you describe your job satisfaction?

How would I describe it? I'm pleased with what I do, its good, yes.

You feel you're doing a good job?

I feel that I'm doing a good job, yes.

Any particular rewards satisfactions in relation to this lecturer/practitioner role

I think the fact that feel that I am still a clinical midwife, that I am still a teaching midwife, and I'm also a practising clinical midwife, that is very, yes, very pivotal to the job satisfaction aspect, yes.

Anything else specifically that you want to identify?

I think there's also the fact that there is always something more to learn, that challenge within the job, which is good because it means you don't get bored, you don't have time to get bored.

Yes.

Which is what I need. Sounds awful.

Right, good, thank-you.

Preparation for the first teaching session

This session is a 3 hour taught session on perineal suturing and the midwifery students are about 8 months into their 18 month programme. They are all registered nurses and some of the them now have experience in suturing from their previous nursing experience and hopefully all of them would have had some observational experience in the clinical aspects of perineal suturing. So the aim of the session is to provide knowledge of suturing for the students and the rationale for perineal suturing so that students have an

increased knowledge of the different suture materials that are available and why certain ones are used in preference to others and be able to have a go at simulated suturing on models practice, so they can learn to handle the equipment in a safe environment.

So what sort of materials do you give them to suture?

We have needle holders initially just a Jcloth so that they can actually suture a piece of fabric together and practice doing interrupted suturing and tie knots with the holders. Because a lot of them at first are so cack-handed really, can't hold the equipment and then, so its really to get them used to holding equipment, how to hold a needle holder

You probably do, but do you get them to assess whether the tear needs suturing or not and all that sorts of criteria?

Yes

and the students have already had a session on pelvic restructure and the perineal body which is the part of the vaginal wall and muscle must be sutured, so its applying that knowledge to the actual practice of suturing and they will have gone through the various degrees of tear of episiotomy as well, so applying that knowledge to the actual practice of suturing of using the materials etc
I also use a video which is done by a suture material company and, of suturing, so they can actually see the video first and be talked through why it is being done, suturing is being performed and then I get them to have a go at actually tying knots to begin with and then I put the video back on again usually so that they can then relate a little bit more to what they've seen, and then have a go at actually practicing on the foam pad and breaking it down into various stages of suturing, so that they can observe my technique of suturing and actual practice and I'll come round and examine what they're doing, make sure that I see each student and that they are getting the technique right and give them tips and they they'll come back and observe me doing the next stage of the suturing and carry on that way.

How many students are there?

There are 15.

Right, so that's not too bad sort of being able to observe each student using the materials

In fact I mean this, within the session there is an hour and a half of actually practicing suturing so it seems like a huge length of time but it is taken up with demonstration and practice

I'm sure, yes.

And usually by the end of the session they will have handled the equipment and developed some familiarity with it

We'll discuss post suture care, but so already discussed in previous sessions and going through it again just to highlight to the students to remember to talk to the women about pain relief and the video actually highlights that as well, so so that again is another taught session and also, this is really a very practical session but applied to the care as well, so

that is makes sense.

Right. So you're aims really for the session are what?

To really provide the knowledge of perineal suturing to the students and give them a chance to practice using the equipment

And can you just go through with me how you're actually going to structure the session, you've said there are opportunities to practice, and see the video that you are actually going to be starting off with the video I think you said?

Yes, well first of all I am going to introduce the session and just explain what I hope to achieve then give time for students to tell me what they've observed in practice, so and what they've perhaps also done in practice, so that I can build on that when I discuss with them as we go round. And some of them may have already had a chance to practice suturing and then I'll show them the video of suturing which is excellent very detailed and includes the important physiology and then send them off to have a practice with the simulation materials then I'll mix with them so that I can observe what is going on. If I feel its needed, if I feel that the students were actually not understanding it, then I'll demonstrate bits again and the video and we have also got an actual model which shows the breakdown of vaginal wall and the muscle layers etc

And then at the end of the session help them to identify their own ongoing needs in order to develop a level of competency in suturing and a reference list to support the practice of suturing so that I can access more material themselves if they need it.

Yes

It is with delivery yes, because we have this discussion a lot actually and I'm not at all averse to them suturing left handed if its their dominant hand, I want to see a left handed midwife delivering in the opposite side, but there's lots to discuss. And it is really from the fact that everybody deals with the women on her right side, so you always have to practice from that side which I disagree with

Yes, absolutely. Anything else?

No.

Thank-you.

Amy BSc Hons Midwifery 15 sts Perineal Suturing

| | | | |
|---|---|---|---|
| 1 | 10 | A led intro to session and colleague who will assist her A Q Sts. A from own experience A indicates that this will be an interactive session and that sts. will draw on own experience from life and from practice A Q re what sts. have seen in practice episiotomy and tears have seen Drs and Mws suturing and explaining what has | A led Q & A Q &A A reassure sts. re issues and complexity of the skill required |

| | | |
|---|---|---|
| | happened before and after suturing. A discusses issues re experience and encourages sts. that they will be the best in their practice and that that will have an impact on patient care | discussion |
| 1 15 | A discusses consent from patient for procedure and use of analgesia both local and entonox issues of pain and communication with patient A comments on research done on patient perception re pain and emotional and psychological trauma ? epidural analgesia Sts. can use PLEs and obstetric notes and past experiences of delivery crucial that the care of patients at delivery and suturing is excellent NB privacy and embarrassment | sts. contribute<br>A led<br>A led sts. contribute |
| 1 20 | For optimal care for patients suturing should be done asap. following delivery therefore for midwives to be able to suture is part of being able to provide holistic and continuous care for women. A comments on own practice and being able to follow through care post-natally A suggests. that when students are happy about their own technique students ask their mentor following this session for the opportunity to suture in practice on real patients | A led sts. contribute<br>A led sts. contribute |
| 1 25 | A leads discussion re pre and post registration issues and the fact that some mentors may not be able to suture themselves important to let lecturing staff know if there are any problems in relation to this links to UKCC code and extended role eg IV cannulation etc | A led sts. contribute |
| 1 30 | A intro video re suturing | A intro video |
| 1 55 | A following what video has shown demonstrates practice suturing A gets hold of needle holder and demonstrates ratchet students all follow suit A opens pack and shows how to do this without contaminating the suture material students discuss with each other as they try it out all focussed on activity<br>A asks how they found this exercise Discussion re particular issues for left handed people and how to hold a needle holder A stresses that all will develop own technique. A demonstrates how to do an interrupted | Materials for practicing suturing given out to all students<br>A checks all students technique<br>A Q and A re this laughter and discussion with each other as they |
| 14 05 | suture all practice A shows how to tie a knot using the needle holder to thread through | practice<br>laughter and chat |
| 14 15 | A and colleague check all students to see that they have grasped the technique some assisted as they need to<br>A chats informally with some sts. and checks and helps those who are unsure reassures sts. ask re technique A answers and demonstrates to those who need it<br>A led discuss suture materials and techniques<br>Sts. practice and discuss with each other what they are doing ask A or colleague when they have difficulty A | Sts. practice A & colleague check<br>Sts. Q A A<br>Sts. chat and help each other<br>A sees all sts. |
| 14 45 | sees sts. and reassures and demonstrates as necessary | A circulates |

| | | |
|---|---|---|
| | Students given further practice material to make practice more realistic | clip of video revisited |
| 15 00 | Video revisited again and A and sts. compare techniques with video | A led |
| | A led highlights main points from video and what has been done so far<br>Sts. put into 2 groups 7/8 in each and one works with A and one with colleague who demonstrate actual suturing on a model A talks through what she is doing | A & colleague led demonstration to sts. in 2 groups |
| 15 10 | and describes the differences between vaginal wall muscle and skin<br>Sts. start to work on own models move chairs to get | Sts. work on own A helps individuals |
| 15 30 | best light A moves around group and works with individuals who ask for help<br>A discusses examples from practice with small groups | Sts. work on own A helps individuals |
| 15 40 | of students while they practice discuss techniques of delivery in order to prevent tears or need for episiotomy | A demonstrates sts. practice |
| 15 50 | Technique of skin closure demonstrated by A sts. practice this on models<br>Discussion re when and how students can practice | Discussion A led |
| 15 55 | suturing and how to develop technique n reminds sts. re universal precautions and body fluids<br>A draws session to a close by recapping on what has been covered and tells sts. where resources such as | A led<br>sts. clear up equipment while still listening to A |
| 16 00 | the video and practice materials can be found both in College and in practice situations<br>Finish | |

It's 4.20pm, so you've just done your marathon 3 hours.

I have.

How do you feel it went?

I felt it was a bit bitty at times and its the first time I've worked with Gemma on the suturing bit and Gemma's another lecturer/practitioner and even though I've gone through what my plan for the lesson was and how we were doing it, I did feel that Gemma was doing it her way rather than the way that I'd said we were doing it, which was difficult really because those students were doing it a different way to the others and the idea was to be sub-particular at the end and Gemma side-tracked and did it before that. So that was a bit awkward. I did go and check that they were on target as well which they were and I did chivvy Gemma up and one point. The students, I think on the whole really enjoyed it, actually getting their hands in and doing it and what I've noticed before with this session is at first they don't know how to handle the equipment, at the end they're just doing it and because its so easy to apply to practice they can see the real need for doing it. Even though it was a small group there were so many questions come out.

It would be difficult to deal with a bigger group wouldn't it.

Huge, yes, yes. You really have to keep them moving with a bigger group and this room wouldn't be conducive for a bigger room at all. I think perhaps a little bit longer would be useful, if is an introduction to suturing and you do usually pick it up further to the end of their training as well, so its revisited. But overall I was pleased with how it went and I feel the students learnt what I wanted them to learn and to put it into practice?

If you were going to do it again, would you do it differently?

I'm not sure that Gemma followed the guidelines/lesson plan, scheme of work as such, I think probably have longer in time as such.

Right. Can you try and identify what examples you used from practice, I mean, I know the whole thing was embedded in practice inevitably, but what was it you were able to bring to that session that perhaps one of the other lecturers who's not in practice couldn't.

I think the fact that I currently suture and it when it comes to handling the equipment and doing the suturing, it is recent practice on that aspect.

I think I heard you talking with the group over there at one point, that, something about last week, I don't know whether that was, I thought I heard you say something about, well the last time I did, or something.

Yes, I can't remember what I said, but I do relate to what I've done.

I think it was on, looking at.

Oh yes, the anal sphincter, yes, yes, so its actually, yes, I do bring in what I see clinically. Personally what I see clinically and also what I've seen happening in practice from others, if I've been assisting a doctor or what I've picked up from people talking, so I do bring a lot of what I've seen recently in and I don't necessarily always talk about it, but I can relate to what students have said and pick up on it and help them try and draw them out, what they're trying to get out.

I mean, there's quite a sort of banter about, you know, when are we going to get practice to do it.

And so again, for the fact that both of you are in practice was

Helpful.

Yes, yes it was. When they were saying, oh we never, or oh we can't, which was very much a student response nice excuse.

I know, and I did ask them to feedback to me if they had problems, and on that I have to make sure that I ask for the feedback otherwise it can get forgotten with everything else that happens, but I feel I usually do follow up on what's happening and then I'll feed it back to the link lecturers and say, can you follow this up, or bring it to a midwifery teachers meeting, on practical issues. Because I know, being in practice, I know that its just so busy, that you're just doing the job and its very difficult to say, got a bit of time, lets

get the teaching pack out and lets do something, but I know at Medway, they have teaching material.

Yes, yes, whether we use it or And again its quite interesting at the beginning, when they were talking about their own experience, and there as obviously feeling, particularly with these two young men about people not wanting to use their expertise.

Yes, I find that very worrying, that midwives, who have gone through their training, who are in practice are very reticent to be observed, in fact, I think professionally that is very concerning. Are they so worried about their practice they don't want to be pulled up on and its very difficult as a student if you have a midwife like that because you are not going to learn and then as a lecturer, that's something to pick up on.

Yes, I mean, this thing about you know going out and getting the practice the student is perfectly capable of doing it, whereas a midwife .may have lost her skills.

Or never had them in the first place, and that aspect is threatening for midwives and I pick that up as a link lecturer, that their the expert teaching a student who suddenly is an expert in something the midwife isn't. Some midwives cope with it excellently and just get on with it and learn other midwives put up barriers everywhere. I'm sure it happens in nursing as well and just stop students being the expert, to keep the power aspect, I'm the expert, you're the student and that is something I try and draw the student out on, so that I actually pick up whether they are being treated as people or as a student who doesn't know anything, and I pick that up again when I do workshops in the clinical area to try and inform midwives, that these nurses/midwives and have a lot of experience.

So the actual, some of the equipment, the sort of foam rubber, foamy stuff, was actually crumbling and causing problems. Was there any way that, would you feel that that was something to address or was it?

It is something to address and we have addressed it with the company that provides it and yet this is the best foam that they can provide for the simulation for the use, and it actually crumbles less when you become more adept, which is very difficult when you are not adept to begin with and it crumbles apart. This group actually did very well and it didn't fall apart as much as other groups. But its not an easy one and even the bits that Gemma brought in, the other suture pads are realistic for some things, but not for the whole aspect of suturing. And the only way to do it is by really doing it on a real person. But this gives them, I think as near as you can, to the confidence of having a go.

Anything else you want to comment on how the session went?

Its an exhausting session, because its observing, being there watching everybody, listening to everybody, and allowing people to make a mess of it and say, its OK, try again, its all right, we'll leave that and recognise that they've learn from making a mess of it and encouraging them through it as well. So it's trying to be positive for them all the time, but yes it's exhausting.

Yes, absolutely. Something I thought was really good was the use of the video with the equipment because they are, they've all had 8 months experience and are actually fairly familiar with the mechanics of it all and seeing episiotomys or they've seen tears or whatever, and so, sort of the actual reality on the screen as it were and then the other

thing, is the model the foam stuff, it was quite good bringing that together. I think if you'd only had the foam, it wouldn't have been

Its not as realistic, yes.

You know, their minds wouldn't have been quite switched on to reality or human flesh as it were, but I think if you'd just had the video and hadn't had something to practice on, something would have been lost there, so I think that was very good. Thank you.

Thank you very much.

Preparation for Second Session

Amy is going to be doing a session at 9.00am with midwives and is going to talk me through the preparation for it.

The subject is the male and female reproductive systems and my working on the premise students should know a lot about this, they are registered nurses and a lot of them would have done gynae experience and just been working as midwives for about 9 months, student midwives for about 9 months now. So my assumption is that they do know quite a bit.

and the anatomy as well.

They should have done, some of them would have done yes. So I've planned the session really assuming that they do know a fair bit and on that aspect I want them to, I've got a questionnaire, its not really a questionnaire, just diagrams of the anatomy of the human male, female and male reproductive systems and I want them to initially just fill them out, working in twos and fill them out so that they can see what they actually do know and so I planned that to really take about 10 - 15 mins and once they've done that I've got the answers on an acetate with the diagrams and I've also done for myself, to jog my mind in case they ask questions, what each aspect is that I want them to be remembering so that we can just go through it in a discursive aspect. So that really is the idea of the session and also just the knowledge that they hopefully will either unearth again from their brains and just talking it through again so they will be able to apply this much more to their practice as midwives.

Right, so its women that have been practicing student midwives, so their working as student midwives, learning student midwives for the last 9 months, so is this the first time they've come across this sort of anatomy?

Have they done anything to do with the pelvis or measurements, that sort of things?

Yes, they've done the pelvic measurements, pelvic floor and the body of the uterus, fallopian tubes, cervix in relation to labour, so its not looking at the more in-depth aspect but just the general background to the male/female reproductive system and in some ways really the session should have been done a bit earlier in the programme, but we didn't realise that it hadn't been put in so we put it in for now, so at least its come through.

So, really the aims of the session are for them to revise, well to revisit but also to be really quite clear on the anatomy and physiology presumably of the male and female reproductive system.

Right good. Anything else?

No, that's it.

Right, thank you.

Amy T 2 BSc Hons Midwifery 15 students 14 12 00
Male and Female reproductive system

| | | |
|---|---|---|
| 9 05 | A introduces session revision of anatomy important for midwives to have a detailed knowledge of the male as well as the female reproductive system<br>Asks students to work in 2s to complete handout A is available to answer questions from sts. | A led laughter handout sts. work together A walks around and comments to |
| 9 15 | A negotiates with students to have another 5 mins | some students |
| 9 20 | A announces that she will give answers on OHP and go through the handout in detail<br>A Q How did you find that? Sts. murmur much harder than thought would A comments that sts. can correct their own handouts and that she will give them information about where to find answers if they want to look up further following the session<br>A explains male and female organs clitoris and penis and anatomical similarities | OHP<br>A Q Sts. A<br><br>Sts. laughter? embarrassment at lack of knowledge as well as subject<br>A led |
| 9 25 | A links anatomy of fourchette with suturing last week discusses anatomy and practice, Bartholins, perineum and delivery technique<br>A any Q re first OHT 1 st where is the Broad ligament?<br>A A and discusses physiology | sts. laugh, comment and contribute<br>Q & A |
| 9 30 | A explains OHT blood supply female reproductive tract sts. contribute and question | OHP A led<br>Q & A discuss |
| 9 35 | A led male reproductive tract discussion of information and terminology eg. spermatozoa link with physiology male hormone FSH link with practice eg. undescended testes | OHP<br>discussion and good natured banter sts. very engaged with |
| 9 45 | A led continue with anatomy of male reproductive tract and physiology link with prostate gland and functions of<br>A led Q What is the composition of semen?<br>link with practice - intercourse know to be a trigger for labour - prostaglandin | subject OHP<br>Q&A<br>discussion |
| 9 50 | Discuss physiology of morning after pill in relation to the physiology of male and female reproductive tract<br>Discuss physiology in relation to conception pregnancy | discussion<br><br>A led and |

| | | |
|---|---|---|
| | and labour A any questions? | discussion |
| | A would like to have had anatomical models for you to look at and see sections of but they have all disappeared must be some funny people around here! | laughter |
| 10 00 | Finish encourage you to look up further to check knowledge of anatomy in order to understand physiology and normal pregnancy and labour | A led |

Right, Amy has just done the session with the student midwives on the anatomy and physiology of the male and female reproductive tract. How do you feel it went?

I was basically that it went as well as it did seeing as it is the first time I've done this one. I think it highlighted to the students that they didn't know as much as I think they may have assumed they did and that it might have, 'I thought it was a waste of session, we know this', and yet realise that they didn't really, so the handouts were useful

I mean even the two young men who you commented that their training is much more in-depth in terms of physiology, but they said they had forgotten it all.

That's right yes, so I thought it was a good refresher session and so my assumptions that it would be a refresher were founded really, were sensible. Using acetates I felt at times it got a bit with what I was saying to what we were looking at to my explanations and I feel that was more so because it was bit more of a cram session, having to be an hour and I would have liked a bit longer to be able to go through it a bit more with a more discussion and perhaps with perhaps acetates and handouts they could really get to grips with it. But I knew that I probably wouldn't be able to do so much with the session, so with the constraints of the session I felt I achieved what I wanted to and also was able to help them to think of it in application to practice, looking at situations and things of fertility, pre-conception.

Yes, I was going to ask you that, how do you feel you brought practice in? I mean I could see obvious links, there were some parts of it in a sense that you know, it was very much straight sort of science really, clinical science, but there were other bits where?

The aspect of, I'm glad the student brought up about female circumcision, that aspect about needing to know what the normal male external genitalia looks like. With pre-conception care and the length of time that a sperm is available to fertilise an egg and how long its been sitting in 'storage' so to speak and also the fact that with the older mother, with downs-syndrome just bringing in those issues and the fact that the, for the baby girl the ovum is really theirs from right at the beginning of gestation and just to highlight to them the actual practical application and how it actually pans out in practice.

In a sense some of them demonstrated some quite muddled thinking, I mean this, you know, with babies, the effects of hormones on babies, there was one girl talking about whether why don't boys bleed.

Yes, yes, that's right, that was interesting, why don't boys bleed, because they haven't got a uterus, and sometimes they think on their feet and if they thought silently they'd have

worked it out. But that in some ways is good that they feel they can contribute whether it's right or wrong or indifferent and on that aspect I'm glad that they actually brought forward issues they could say things and say oh that wasn't right, its shows that the group's safe and that they can learn within that. Another aspect is that they seem to not mind you sitting here and they just carried on the same which was good.

Yes, that's good.

So an interactive session again which was helpful.

If you were doing the session again, would you do anything differently?

I'd try to have longer, definitely have longer and that was hugely unforeseen as we needed to fit something else in and I would like to have had the models, actual working models without bits missing, really annoying that. So that needs to be really looked at and actually then they can have a look and go around and see the models, work it out, apply it and to have longer so that they can just look at things and whatever. But for a short sharp session for an hour it went well and I was quite concerned to get a lot in, in a short time without being too didactic.

No, I think the use of the incomplete handouts was a very good strategy wasn't it.

Yes, yes.

Great. Anything else?

Student feedback I found was good and that they, I did ask them if it was a useful session because its useful to know that at this point and they said yes.

Yes.

And I could see that is was from just looking at their faces and how they were joining in.

Yes, yes.

So that was good.

Anything else?

No.